Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dep/ 2012 JUIT 12:16A M Dennis Weber Bruce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Smithsburg Washington 11814 Keifer Funk Rd. Social Security Number 6 Sev If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours 401-50-3354 Sept^{nth}1^D1^y, 1938 Kentucky 73 1X M 2 D F Director Yrs Usual Residence of Decedent items 23a or 28a-f show 10b, County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 🗌 Yes 2 😾 No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11814 Keifer Funk Rd. 21783 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Yes 2**X** No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Welding Supply Company 12 4 Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Albert Weber Evelvn Lavenia Hykes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Linda Weber - Wife 11814 Keifer Funk Rd. Smithsburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBuriat Cremation 3 Removal from State Donation 5 Other (Specify) July 13,2012 Williamsport, Maryland Greenlawn Mem. Park 22. Name and Address of Facility Osborne Funeral Home, P.A. Signature 425 S. Conococheague St. Williamsport, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ck, or heart failure. List only one cause on each line. Interval Between Onset and Death ediate Cause (Final Physician/ sease or condition resulting in death) renary Medical Due to (or as a conseque co of) Examiner Sequentially list conditions, Examine if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician ar the burial-t Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be rostate C 2006 Box 68760 attending pl for use as t yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed? ☐ Yes 2 X No 2 🗌 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 Yes 2 No 5 Pending I Director A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continued Research Continued at the time of the cause (s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KO64128 7-10-2012 wi CRN 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 142 Hagerstown MD 21742 JW-10 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}, 2012 July Physician/ 7:00P. M Mary Candis McKee Washington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Citizens Care & Rehab, Frederick Ctr. Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) Director 165-46-3950 1 □ M 2 □**X** 72 4/6/1940 N.C. th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No PA Allegheny Clairton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 515 Wilson 15025 USA Ave, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other ti <u>Homemakeı</u> Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Roland McKee Annie Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Price (Daughter) Price va Denise Washington 21702 injury or other Cumberland Court Frederick, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Round Hill Cemetery 7/13/12 Elizabeth Twp. 22. Name and Address of Facility Robert A. Walters Fun. Home 21. Signature of Funeral Service Licensee m01035 selver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final COLAN Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months? Month Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significant and funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifics completely filled in by the funeral director, t Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier MD 30. Name and address n who completed cause of death (Item 23a) (Type, Print) s of pers TOLL HOUSE 801 SYE

Registrar DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anita June Wiederhold July 4,**2012** 11:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Twin Oaks Assisted Living Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F **Director** 219-20-7968 95 March 31,1917 Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16043 Cloverton Lane 21795 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Deces? Armed Forces? ¹ ☐ Yes 2 🗶 No Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with and Mental Hygien 7 is marked other the Owner/Operator Restraunt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Eugene Ardinger Airy Adna Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or Atlant Judi Grimm (Daughter) 16041 Cloverton Lane Williamsport, Maryland 21795 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Greenlawn Mem. Park July 9, 2012 | Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Hyperlen DIVE disease or condition resulting in death) Medical Due to (or sa consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 1 Yes 2 L 9 Unknown as been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes wellily sterious, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp this 27. Manne Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State

29b. Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

380.C

strar's Signature

Mahmod

Northern Au Hagerstown MD 2174

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day June 28, 2012 ar Peter Wilbur 3:00 PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4828 E. Basford Road Frederick Frederick If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Hours Min. 216-38-0884 August 21, 1935 Washington, D.C. Director 76 1 ₹ M 2 □ F Usual Residence of Decedent I Hygiene. . other then "neturel", or items 23a or 28e-f shov vent, the Modical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4828 E. Basford Road 21703 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1958–1960 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) I end 2 should be filed Heelth end Mentel H tem 27 is merked ot 18. Mother's Name (First, Middle, Maiden Surname) Herbert Wilbur Margaret Noel treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Wilbur / Wife 4828 E. Basford Road, Frederick, Maryland 21703 Baltimore. Importent: If item eny Injury or other 20a. Method of Disposition

1 Dunial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pege 1 e Department of H 20c. Location - City or Town, State Date Smithsburg Crematory June 30, 2012 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licensee MO1473 Keeney and start ord PA Funeral Home, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure faist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Covinan Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): In the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 5 Other (specify) Month Pregnant at time of death 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by I Records, setes melectus 1 Yes 2 No 3 Probably 4 Unknown Hyporlifidence 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 N Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 agu 610 Muck Mo State Registrar CHELA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#12 per FH 1 - State Registrar 6/29/2012 AACO HEALTH DEPT. CMH. Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert M. Wright 3:35 P M 2012 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 330 Kingsberry Drive Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) 022-28-3444 Country) Director 1 X M 2 D F 73 April 26,1939 Massachusetts Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits MD Anne Arundel Annapolis 1 Yes 2X No the 1 10e. Street and Number ō 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 330 Kingsberry Drive 21409 USA ir than "natural", or items the Medical Examiner mu and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 196 1 X Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1961-Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1965 "natural", 1 ☐ Yes 2X No Specify: Specify White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attorney Legal injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Sellers Ernest Allen Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Nancy Wright / Wife 330 Kingsberry Drive Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot June 27, cemetery, crematory or other place 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Metro Crematory, INC. Baltimore, MD 2012 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, Severna Park Funeral Home Severna Park, MD 21146 P.A. 495 Ritchie Hwy, 23a. Part 1. Enter the desease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart future. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ung cancer Phymician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the ar 1 ☐ Yes ∠ L g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate I 1 ☐ Yes 🔭 No director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29d. Date signed (Month, Day, Year) Thomas M. Walsh M.D.

State Registrar

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de +

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS M WALSHMD , 125 Shoreway Drive Queenstown, MD 21658

D23867

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. EOAMEND#31 per HD State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 6/29/2012 AACO HEALIH DEPT OMH Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Day **Physician** WILLOX 3:15 P M 27, 2012 /Medical June 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harmon entreville MD24 Hrs. 8. Date of Birth Min (Month, Day, Birthplace (State or Foreign Country) (In vrs. last birthday **Funeral** Months Year) 1 M 2 F Days Hours 171-22-6871 Director 06/15/ Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Centreville Oueen Anne's MD ral", or Items 23a or 28a-f sh Evantrar must be notified. Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21617 853 Harmony Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 195 197es 2 No If Yes, Give 195 Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1951-1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify White Completed by 1955 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bell Telephone Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Allen Willox ဥ Lena Caroline Wenner other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Marie Willox / Wife 853 Harmony Way Centreville, MD 21617 Baltimore. 20a. Method of Disposition June 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Metro Crematory, INC. 2012 22. Name and Address of Facility
CREMATION DIRECT 21. Signature of Funeral Service Licensee 495 Ritchie Hwy. Severna Park, MD 21146 23a. Par 1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown as failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INEUMONIA Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burlal-trai Due to (or as a consequence of) Box 68760, physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 □ Yes No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Certification: To 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Desidence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Leath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 4 hours after death. Natural 5 Pending 2 Accident To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) MD MPH DOOSTOOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Bowyer MDMPH Stc. 101 Centreville MD ZILLIE Carswall

Registrar
DHMH 17 Rev 1/2001

State

JUN 2 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6/30/2012 Day Year 7:20 A Mildred Louise Ward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Berlin Nursing & Rehabilitation Cen Worcester If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Hours Min. 9/17/1916 95 Washington DC Director 577 09 1753 Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, th. Medi-al Examiner must to notified 1 Yes X No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20 West Mallard Dr. 21811 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Midowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 1 and 2 should be filed within 72 f Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Thompson Jenny Embry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet W. Booth (daughter) 20 West Mallard Dr. Berlin, MD 21811 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Grove Baptist Cem. 7/2/2012 4 ☐ Donation 5 ☐ Other (Specify) Goldvein, VA . Signa dre rvice Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that cause of the death. On not enter the mode of dying, such as cardiac or respiratory prest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) ces Medical Due to (or as consequence of): Examiner 2 Securetially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-transit Due to (or as a consequence of): Box 68760 the attending ploched for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No s been signed by the s 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed death? 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the only one) 3 [Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. 9715 Robins Healthway Drive Berlin, MD 21811 31. Date filed (Month Pay, Registrar's Signatu State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2} \underline{012}$ Physician/ Month <u>Virgini</u>a June 16:40 P M Hannah Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days **Director** 1 🗆 M 2 💢 F 246-38-2645 83 Jan 11, 1929 North Carolina iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location Director District of Columbia Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20009 3023 - 14th Street, NW #603 United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican "natural", or 1 Never Married 2 Married þ Yes 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Giv 3 x Widowed 4 □ Divorced Completed Year or Dates American event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry uld be filed withind Mental Hygiene. (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nurse-LPR Government 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ဂ္ Thornton Gorham, Sr. Carrie Brown and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Carlos H. Gorham - Brother 909 South Belgrade Road Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Cedar Hill Cemetery July 7, 2012 Washington, NC 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home, Inc. Stern John I-M00560 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Hypoxia Sequentially list conditions, if any, leading to immediate cause E ter Uncernity Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir Pulmonary Hypertension death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 the attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy5 Other (specify) ____ Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? To the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 Yes 2X No Division of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔁 No 1 🗌 Yes မြ 1 x Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 29, 2012 D67589 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 1500 Forest Glen Road Silver Spring, MD 20910-1484 Harold V. Lawson

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 5 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOI	epartment of Health and N	Mental Hygi	ene	
		_	State Registrar	Certificate of Death	Re	g. No. 2	2 23009
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month		3. Time of Death
	Medic		Anne Yeh		June 28	3, ^{Day} 2012	11:28 P™
3	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
	Ermanol		Medstar Montgomery Medical Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthde	Olney If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgor	nery Birthplace (State or Foreign
	Funeral Director		028-16-5807 1□M2⊠F 88 Yrs	Months Days Hours Min.	(Month, Day, \	Year) (Country)
			Usual Residence of Decedent		Nov. 8,	1923	MA
	yland f sho	ctor	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	Mar 28a notifi	Director		lver Spring			1 🗆 Yes 2 🏝 No
	ith the	ral	10e. Street and Number 2709 Briggs Road	10f. Zip Code		0g. Citizen of What	Country?
	ath w	Funeral		20906 13. Was Decedent of Hispanic Origin? (Sp		USA	merican Indian,
ပ္	or ite	by F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.
03	rs aft	ed k	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: F	Asian
5-0	2 hou "natu	Completed		ecedent's Usual Occupation ive kind of work done during most of work	rina 1	16b. Kind of Busine	ss/Industry
121	hin 7 ne. than	mo;	Elementary/Secondary (0-12) College (1-4 or 5+)	e. DO NOT use retired) memaker		0 1	
D	Hygie Hygie other ant, th	Be (17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	Own Ho	ome
an	be filk ental ked c	70	Yuen Wee Chin	Yu Ge S		alderi Surriame)	
Maryland 21215-0036	should be file and Mental F is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. M	lailing Address (Street and Number or Rur		City or Town, State.	Zip Code)
Ξ	d 2 stath a alth a 27 is	17		9 Briggs Road, Silv			
ore,	of He fitem			isposition (Name of crematory or other place)	Date 10,	20c. Location - City	or Town, State
Ĕ	Page ment ant; I ury o	П	I Dullar Z Dicination 5 D Nelloval Itom State			lexandria	a, VA
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Francis J. Collins 500 University Blvd	Funeral	Home Inc	
_	<u></u>		Mus M Glerge	500 University Blvd	W., S1	lver Spri	ng, MD 20901
			23a. Part 1. Enter the disease, or complications the caused the death. Do not shock, or heart failure. List only one cause or each line.			st,	Approximate Interval Between Onset and Death
-	Physician Medical	Ĥ	Immediate Cause (Final disease or condition resulting in death)	LENAL Bleed	ling		Onset and Death
-	Examiner		Due to (or as a consequence of):		,		
		Jer	Se uentially list conditions, if any, leading to immediate Due to (or as a consequence of):				-
	pet T	Examiner	cause. Enter Underlying Cause (Disease or injury				
	exect an and rial	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
09	icate be executed physician and is the burial feet	dical	d				
87	rtifica ing ph e as t	ı w	IF FEMALE:				
Box 687	attending p	ian/	23b. Was decedent pregnant in the past 12 months?			23d. Date of Month	delivery Day Year
ğ	e dea the a	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown Unknown	5 Other (specify)		World	Day Tou.
P.O.	hat thed by detact	у Рһ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did toba	acco use contribute	e to the cause of death?
S,	requires that the dec been signed by the should be detached	Completed by Physician/M	Asserding Cholangitis, q	ram negative	e 1 □ Yes	s 2 No 3	Probably 4 Unknown
orc	v requ	olete	Carele	7	24a. Was an		autopsy findings available
3ec	sician: The law is certificate has build director, page 2 s	lmo			autopsy perform	ned? death	to completion of cause of 1? Yes 2 \sum No
a	ian: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec		. 2 110	163 2 110
ž	hysic nis ce Il dire	To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing H	ome 5 🗆 Resider	nce 6 Other (Sp	pecify)
ı of	ing P	ate:	27. Manner of Death 1 → Natural 5 □ Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) injur	ry work?	28d. Describe hov	w injury occurred	
ior	ttend death tor: A	Certificate:	2 Accident Investigation	M 1 Tes 2 No			B 18 1 North
Division of Vital Records,	I or Attending Physician: The la after death. Director After this certificate ha in by the funeral director, page	Cer	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,		Rural Route Number,
	spital nours neral / fillec	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	and due to the caus	se(s) and manner as	s stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial forms.	Medical	(Check 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred a	t the time, date and	d place, and due to the	he cause(s) and manner stated.
	Vithi To the	_	29b. Signature and title of certifier	29c. License number	29	3d. Date signed (Mo	onth, Day, Year)
	12		Chillen of the left his	024190]	une 2	8,2012
			30. Name and address of person who completed cause of beath (Item 23a) (Typ	pe, Print)	10 0		204321
			131. Date filed (Month, Day, Year) 32/Registrar's Signature	3416 Oland wood	ICH D	lucy M	langland
	Sta Registra		JUL 02 2012	29c. License number 29c. License number DZY190 De, Print) 3416 O (and week)		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

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8, 2012

21225

M.D.

32. Registrar's Signature

3001 S

Anantha Kumau

Nothalapati

Aniantha

31. Date filed (Month, Day, Year)

2 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-05020 David Allan Biggs	State of Maryland	ack Indelible Ink. Ensure All Department of Health and Mer	Copies Are Legible. ntal Hygiene 20 2 23	0
	1- For State Registrar	Certificate of Death	Reg. No. 2. Dete of Death 3. Time of Death	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) David A. Biggs		July 4, 2012 Year 2156 hrs	
	4a. Facility Name (if not institution, give street and number) Atlantic General Hospital	4b. City, Town, or Location Berlin	Worcester	
Funeral Director	5. Social Security Number 220-88-5810 6. Sex 7. Ag	te (In yrs. last birthday) 50 Yrs. If Under 1 Yeer If Under 1	der 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Fore Country) MID. 2/2/62 MD	eign
> 2	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Lin	nits
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the Maryland a or 28a-f sh Effed at onc	10e. Street and Number 100 Maryland Avenue	10f. Zip Code	21830 USA USA	
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 23a-1 show any natic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or: 11 0	during most of working life. DO NO	Tuse retired)	
21215-003 uld be filed with Mental Hygiene marked other to event, the Med	17. Father's Name (First, Middle, Last) William H. Biggs, Sr.	ي م	er's Name (First, Middle, Maiden Surname) Phyllis B. Sherman	
ID 2121; 2 should be fill 2 and Mental Fi 7 is marked matic event, 1	19a. Informant's Name/Relationship (Type, Print) Virgina L. Hull /Sist		umber or Rural Route Number, City or Town, State, Zip Code) Hill Road, Brooklyn Park MD 2122	25
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be fixed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than injury or other traumatic event, the Medical migury or other traumatic event, the Medical To Be Comple	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from St. 4 Donation 5 Other Specify	Ardent Crematory	Date 20c. Location - City or Town, State . 7/7/2012 Hanover Maryland	
Baltimo permit. Page Department of Important, injury or out	21. Signature of Funeral Service Licensee Victor	Charles L. Ste	evens Funeral Home, Inc. Avenue, Baltimore MD 21230	n vol
Physician /wegical	23a. Part I. Enter the disease, or complications that caused feilure. List only one cause on each line. Immediate Cause {Final disease a Multiple Injurie		ardiac or respiratory arrest, snock, or heart Approximate fine Between Onset of Death	
Examiner	or condition resulting in death) Due to (or as a cons			
red Insti	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	equence of):		
ecuted and and transit	events resulting in death) Last Due to (or as a const	sequence of).		
oe execution and unital - tra	UNPENDED AMENDED			
Vital Records, P.O. Box 68760, sistem: The law requires that the death certificate be executed ins certificate has been signed by the attending physician and director, page 2 should be detached for use as the burnal - transion Be. Completed by Physician/Medical Exp.	IF FEMALE: 23b. Was decedent pregnant in lihe past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outco 1 Live birth 4 Pregnant a 9 Unknown		pic pregnancy 23d. Date of delivery Month Day Year	
ires that the designed by the stander of detached for the detached for the by the stander of the stander o		th but not resulting in the underlying cause given in Pa	art I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Uhknow	
Vital Records, P.O. yskian. The law requires that the his certificate has been signed by director, page 2 should be detact on the Completed by P.O. Be Completed by P.O.			24a. Wes an autopsy findings avails prior to completion of cause death? 1 X Yes 2 No 1 X Yes 2 No	of
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To the Hospital or Attending Physic
within 24 hours after death.
To the Funeral Director: After this c
completely filled in by the funeral dire
Medical Certification: To E Medical

28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 27. Menner of Death Deceased operator of a scooter involved in 1 Yes 2 X No 5 Pending motor vehicle accident 2110 hrs Jul 4 2012 Investigation 28f. Location (Street and Number or Rural Route Number, City

1 Natural 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

2

Medical Examiner: On the basis of examination and/or investigation in my principle death occurred at the time, date and place, and due to the cause(s) and manner as stated.

O.C.M.E.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner

OCME

or Town, State) Ocean Pines, MD 21811

July 6, 2012

31. Date filed (Month Day State Registra

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Albert Bailer 5:44 Medical Examiner 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Randallstons Baltimore Hospital Northwest If Under 24 Hrs. If Under **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 262-55-1853 1**X**XM 2 | F Months Director Yrs 10/20/72 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Randallstown MD Baltimore 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2705 Ashfield Drive #102 21244 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 KNever Married 2 Married should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: **BLack** Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Service catering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sandra Richardson permit. Page 1 and 2 should be fi Department of Health and Mental Important. If item 27 is marked any injury or other traumatic ev John Albert Bailey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Ashfield Drive #102, Windsormill MD 21244 Sampson /Sister Sylvia 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3X Removal from State cemetery, crematory or other place)
Restlawn Memorial Park 6/30/12 Jacksonville, FL 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 11 Es L. Stevens Funeral Home, 11 E. Fort Ave., Baltimore MD Wictor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ESRD Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Live Birth Z Live Fetal Col.
Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 Tes 2 No 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 📉 No ည 1 Inpatient 2 KER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 \(\sum Yes\) 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Certificat 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 10071045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 /s Court Road, Rodallstown 5401 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 119, 2012 YVONNE DORENE BOSS 2:20 P M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 803 CEDAR BRANCH DR. **GLEN BURNIE** ANNE ARUNDEL Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🗆 F Days 565.80.7064 Hours Country) Director 60 OCT 5, 1951 MD Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location must be notified at Director 10d. Inside City Limits ANNE ARUNDEL **GLEN BURNIE** 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 CEDAR BRANCH DR. 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo er than "natural", or ite the Medical Examiner 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygien 7 is marked other th 12 CROSSING GUARD ANNE ARUNDEL CO. GOVT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ano ...
of Health an.
* item 27 is marn.
~ traumatic ev မ SEVERN JOHNSON LOUISE BIERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND BOSS HUSBAND 803 CEDAR BRANCH DR. GLEN BURNIE, MD 21061 Department of Healt Important: If item 2 any injury or other once 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Waurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specif **GLEN HAVEN CEMETERY** 7.23.2012 GLEN BURNIE, MD 21. Signar e o Funeral Service 22 Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW CLEN BURNIE, MD 21061 GRECROY FINK M01148 23a. Part 1. Enter the law se, "complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List or "one cause on each line." Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons-**Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical as the l nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 🗆 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2XX No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident
3 Suicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature 29d. Date signed (Month. Day, Year) 20 2012 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN FORMAN, MD 1406 CRAIN HWY. S. GLEN BURNIE, MD 21061 32. Register's Signature State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ 0148 Medical Name (if not institution give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death ledica NA 8. Date of Birth (Month, Day, Year, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Director 1 - M 2 F 28-1968 items 23a or 28a-f show ner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1 Ves 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? hundale S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married 0 Completed by ☐ Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 han "natural", c 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education aministrative Assistant years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ tha phala Mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Eaton-mother 1002 Comet St Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 MBurial 2 Cremation 3 Removal from State 7-13-2012 Arbutus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funoral Service Licensee 22. Name and Address of Facility (1) March East 1101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ulmonas 30 min Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the k attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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the Funeral Director: After ompletely filled in by the fun 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ap DOOL COZ completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

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Division of Vital	ital or Attending Physician: The law requires that the death certificate be execute urs after death. ral Director: After this certificate has been signed by the attending physician and lited in by the funeral director, page 2 should be detached for use as the burial-trans	Certificate:	4 Homicide			building, e	njury - At home etc. (Specify)	, rarm, si	леет, тастогу,	onice			City or To			arriber of Mul	a riodic ivi	
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1

29d. Date signed (Month, Day, Year)
July 19, 2012

31. Date filed (Month Day, Year)
JUL 20 2012

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 0°1 2 Ronald Sylvester Bright 0535 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 577587450 **Director** 1 XM 2 F 68 2/23/1944 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10h Counts Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** Bladensburg 1x Yes 2 No Prince George' 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5999 Emerson St Apt 622 20710 ral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify Black "natural", Completed 3 Divorced 4 Divorced Year or Dates Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Car Salesman Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Bright, Sr. Annie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,0\,7\,1\,0$ Health a Andrea Bright/Daughter 5999 Emerson St Apt 622, Bladensburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State \$ = 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Department of Important: If any injury or 4/25/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 21. Signature of Prineral 5 22. Name and Address of Facility Capitol Mortuary, 1425 Maryland, NE, Wash, DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Septic Shock Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ... ure Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificant completely filled in her ten 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 06-26-12 D0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Silver SAT

BLVD East

32. Registrar's Sgnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Yvonne M. Burchfield July 18 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1322 Wilson Road Waldorf Charles 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min Hours 1 M 2 XX Director 220 76 6718 71 April 9, 1941 Holland . 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Charles Waldorf 10f. Zip Code 10g, Citizen of What Country? Funeral 1322 Wilson Road 20602 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. Armed Force Completed by 1 Yes 2 No
If Yes, Give XX
Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2xxx No Specify: Specify: White 3 ₩Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Jonathan Unmels Barbara (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Sloan (Daughter) 2244 Wakefield Circle, Waldorf. MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) <u> Arlington National Cemetery(unk)</u> Arlington, Virginia Signature, of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD enneth Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician disease or condition resulting in death) Medical a consequence of Examiner se Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? nerform within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: ြု 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home → Residence 6 ☐ Other (Specify Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☐ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 23a) (Type, Print) 30. Name and address of person who co empleted cause of death (Item filed (Month, Day, Year) 32. Registrar's State 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patricia 2012 5:46 PM Reager Bea1 Ju_{1y} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Hours Director 1 🗆 M 2 🗓 F 403-28-6071 87 June 10, 1925 Kentucky Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Montgomery Bethesda 1 Yes 2 X No ò 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? must be 23a Funeral 9707 Old Georgetown Rd. 20814 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō, þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural" Completed 3 X Widowed 4 Divorced Specify White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Social Services Executive and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Harry Philip Reager Louise Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sment of Health amt: If item 27 i William Ashby Beal, Jr./ Son 3327 Stephenson Pl. NW, Washington D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or Chesapeake Crematory : 07/19/2012 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Tes 1 Inpatient 2/ ER/Outpatient 3 DOA e Hospital or Attending Phys 124 hours after death.
e Funeral Director: After this oldely filled in by the funeral di 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident 1 Yes 2 No Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number nusician

DHMH 17 Rev 06-2011

Registrar

Patricia

MD

32. Registrar Signat

d address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e, 19b per fn g929 7-31-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 1^{Day}, 1:19 P M 2ď°2 Boy11 Patricia Jean Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 01ney Montgomery Medstar Montgomery Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min. (Month, Day, Year) **Director** 305-36-5084 1 □ M 2**X** F 74 Oct. 24, 1937 Indiana Usual Residence of Decedent 28a-f shov 10a. State 10c, City, Town or Location 10d, Inside City Limits notified at Director Montgomery Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code World Blvd. 10g, Citizen of What Country? "natural", or items 23a or Funeral 3435 South Leisure Blvd. #2D 20906 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home 12 Homemaker event, 1 Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) 2 Black Hazel Anthony Savant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbe Work (State, Zip Code) 3435 South Leisure Blvd. #2D, Silver Spring, 20906 Robert C. Boyll / Husband 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 07/19/2012 Chesapaeke Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lige Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 or complications that caused the de 23a. Part 1. Enter the disease ath. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) Medical Due to (or as a conseque rice of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami nding physician and use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten I for u in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death
Unknown signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No Director; After this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: hin 24 hours after death. director, 25. Was case referred to ... dical Be 26. Place of Death (Check only one) Hospital ပ Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending 2 Accident
3 Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number completed cause of death (Item 23a) (Type, Print) 8101 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Charles Eric Behre Month Physician/ Day | Year 730 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Lorien Nursing Home** Columbia Howard 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. 8. Date of Birth 9. Birthplace (State or Foreign 225-78-2746 Days Min. 61 Months Hours (Month, Day, Year) Jun 16, 1951 Director 1 M 2 □ F 10a. State 28a-f show ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Dayton 1 Yes 2 No 10e. Street and Number 5159 Green Bridge Road 10f. Zip Code 10g. Citizen of What Country? Funeral 21036 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. g 1 Never Married 2 Married 2 No 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Painter (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Construction Be 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden Surname) Herman Edward Behre ပ Doris Ann Erickson 19a. Informant's Name/Relationship (Type, Print) H. Evan Behre 19b, Mailing Address (Street and Number or Hural House Northway, 5.1.) 5159 Green Bridge Road Dayton, MD 21036 t and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Tremation 3 Removal from State Atlantic Crematory, LLC Jul 17, 2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Nam Slack Funer and Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Ser Part 1. Sitter the disease, or complications the caused the death shock, or heart failure. List only one cause on each line Rhos: S Interval Between Immediate Cause (Final disease or condition Mouths Physician/ Medical resulting in death) **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): executed burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical law requires that the death certificate be Box 68760 the attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 Unknown g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ns certificate has but director, page 2 sh 24a. Was an autopsy performe cate h Hospital or Attending Physician: The 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this of filled in by the funeral direction lursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident within 24 hours after death

To the Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) 201 ah (Dem 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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State ³ Registrar

DHMH 17 Rev 1/2001

OCME 2006

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Russell Alexander MD.

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

OCME

July 15, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,		- For State		•	ficate of	Death			Reg. No	0.	1 1	
Physicia Medical Examin	n/	Decedent's Name (First, Middle, Lo NANCY LEE CHALL	,					2. Date of De Month July 11,	Day	Year		3. Time of Death 0020 hrs
and the second		4a. Facility Name (if not institution, g Emerit 8911 Clemet Ave			4	b. City, Tow Parkville	n, or Location of		4	tc. County of I Baltimore		nty
Funeral Director		10 0000		(In yrs. last	birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	24Hrs. 8. Date of E				pplace (State or ntry) MD .
nd show any oce.		Usual Residence of Decedent 10a. State 10b. County Maryland Baltime	ore	10c. City, To	own or Location		ville				- 1	10d. Inside City Limits 1 Yes X No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 8911 Clement Av	Э.			10f. Zip Co	2123	4	10g. C	itizen of What USA	Count	ry?
or death with	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Armed Forces? 1 Yes 2	Ever in U.S. No	If Y∈	s, specify C		n? (Specify Yes or No Puerto Rican, etc.)	lo-	14. Race - / White, e	etc.	an Indian, Black, nite
2 hour	leted by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com		6a. Decedent during mo	's Usual Occ st of working	upation (Give kir life, DO NOT us			. Kind of Busin	ness/In	dustry
5-0036 led within tygiene, other than	Completed	12 yrs. 17. Father's Name (First, Middle, Las	4 yrs.		Teach	er —		Name (First, Middle	, Maide	n Surname)	re (
21215-0036 suld be filed within 7 Mental Hygiene, marked other than cevent, the Medita	a	Paul A. Challan 19a. Informant's Name/Relationship			19b. Mailing	Address (S	Street and Numb	er or Rural Route N	umber,	City or Town,	State, 2	Zip Code)
MD nd 2 sho alth and alth and am 27 is		Charles P Chall	andes (Bro	ther)	P. O. I	30x 970	2 Baldwi	n, Md. 21	.013	. Location - C		
Baltimore, pemit. Pages l a Department of He Important: If ite Important: If ite injury or other tr		1 XXBurial 2 Cremation 3 4 Donation 5 Other Specia	īy:		matory or oth KWOOD	Cemete	ery 7	-14-2012		Baltim	ore	, Md.
		21. Signature of Funeral Service Lice			74	01 Be		Lassahn Baltimor	e,	Md. 21	236	
Physician Medical Examiner		23a. Part I. Enter the disease, or con failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		erotic					rrest, sl	hock, or heart		Approximate Interval Between Onset and Death
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse									
ed	Examiner	events resulting in death) Last	Due to (or as a conse	quence of):								
760, frate be executed the burial - transit	Medical	X UNPENDED	X AMENDED 44a,	erre G	929 ,7/2	9 <u>7</u> 012,	g929 7-	27-12 sm				
on of Vital Records, P.O. Box 68760, cading Physician: The law requires that the death certificate be executed or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - trans	Physician/Me	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant at	e of pregna	ncy 2 Fet	al death er (Specify)		pregnancy	2	3d. Date of de Month	elivery Da	y Year
that the death certified by the attending detached for use as in detached for use as in the attending detached for use attending detached for use as in the attending detached for use attending detached for use at a tendential detached for use attending detached for use at a tendential detached for use attending detached for use attending detached for use at a tendential detached for use attending detache		1 Yes 2 No 9 V Unknow	3 GIRRIOWII	but not resu	ulting in the ur	nderlying cau	ise given in Part	I. 23e. Did	tobacc	o use contribu	ite to th	ne cause of death?
ls, P.O. quires that then signed by and be detact	ted by	Metastatic Ade	nocarcinoma	a, chr	onic o	bstruc	tive	1 ✓ Y 24a. Wa				bly 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed by	pulmonary dise	ase					auto peri 1 ✔ Yes	opsy ormed?	prio dea	or to co	mpletion of cause of
Vital ysician:	B	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 El	R/Outpatient		Other	theck only one) Nursing Home 5	Resid	ience 6 🗸	Other:	Scene
ision of \alpha Attending Phy rr death. rector: After th by the funeral	tion: To	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	y 2i	8b. Time of In	jury 28c.	Injury at Work? Yes 2 N		how in	njury occurred		
	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of Inj	ury - At hom	e, farm, stree	t, factory, off	ce building, etc.	28f. Location or Town,		and Number	or Rura	al Route Number, City
	Medical	29a. Certifier 1 CertifyIng Physicone) 2 Medical Examin	cian: To the best of my er:On the basis of exan and manner stated.	knowledge, nination and	, death occurr /or investigati	ed at the tim on, in my opi	e, date and place nion, death occu	e, and due to the car arred at the time, dat	use(s) a e and p	and manner as lace, and due	s stated to the	f. cause(s)
Si the signal of	Me	29b. Signature and title of certifier	me l/ M	7			cense number			Date signed ly 11, 2012		h, Day,Year)
- W		30. Name and address o person who				Baltimor	e Street, Bal	timore, MD 212	223			
Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ James William Cox July 2012 11:42 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours (Month, Day, Year) Director 219-22-7579 1 XM 2 □ F 85 April 29,1927 Baltimore, MD. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street of Health and Mental Hygiene. The street is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Maryland Baltimore County 1 Yes 2 No Timonium 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 208 Burning Tree Road 21093 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Auto Salesman Auto Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Burton Nolan Cox Ethel Minor 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elizabeth (nee Melville) Cox 208 Burning Tree Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemeter), crematory or other place).

Fvans Funeral Charge and Cremation Services, inc. 20a. Method of Disposition 20c. Location - City or Town, State (Harford County) Wednesda permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State July 18,2012 Forest Hill Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. FS 22 Name and Address of Facility ives Funeral and Cremation Center, P.A.

22. Name and Address of Facility ives Funeral and Cremation Center, P.A.

23. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. FS 22 Name and Address of Facility ives Funeral and Cremation Center, P.A.

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24. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. FS 22 Name and Cremation Center, P.A.

25. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 23a. Port 1/Enter he disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listenly one cause on each line. Approximate Interval Between Immediate Cause (Final Ischemic carpion you Thy Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 4 Pregnant a Pregnant at time of death 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1)X(Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 s autopsy Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence & Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

X 0,

State Registrar

only one) 29b. Signature and title of certifier

MARON 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANGES M 6701

32. Registrar's Signature

10 Charles

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH. G929.7/27/2012 WS
State of Maryland Department of Health and Mental Hygiene
AMEND ITEM#7perFH, G931, 9/26/2012, WS

Certificate of Death

Reg. No. 2012 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Alberta Campbell 9:30 P July2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year)
MAY -5 1924 Hours 82 88^{Yrs.} 578-40-7252 1 □ M 2 🛣 Director Georgia Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Yes 2 No Md Prince George's Riverdale 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? must be 23a Funeral USA 4601 Tuckerman Street 20737 items death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Medical Examiner Armed Forces? Black, White, etc. o þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black If Yes, Give Year or Dates "natural", Completed 3X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Private Laundry Worker 11th event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Annie Rogers Charles Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Dunkley/Dgt. 4601 Tuckerman Street Riverdale, Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Ft. Lincoln Cemetery 1 X Burial 2 Cremation 3 Removal from State 7/18/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. 7474 Landover Road Hyattsville, Maryland 20785 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, others failufe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ung disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has by page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 3 La Suiciae 4 La Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 52326 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Kennedy Lightfoot Jr. M.D. 20019 Century Blvd # 200 Germantown, Maryland 20874 31. Date filed (Month, Day, 32. Registrar's Signature State arka Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elizabeth Renee Carlton State of Maryland / Department of Health and Mental Hygiene 2012 23026 1. For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day July 5, 2012 **Medical Examiner** FLIZABETH 1524 hrs RENEE 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 217-06-3248 Country Maryland 12-13-83 1 M Usual Residence of Decedent IDY 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 V No 28a-f show 'natural", or items 23a or 28a-f sho with the Maryland 10e Street and Number 10g. Citizen of What Country? 靣 Funeral 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 No Yes 3 Widowed 4 Divorced 1 Yes 2 No specify: permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In prortant: If item 27 is marked other than "natural", in jury or other traumatic event, the Medical Examiner. Specify: <u>څ</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collsga (1-4 or 5+) Baltimore, MD 21215-0036 TOMEMAK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANDREW ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KRIDGE MD - 210 IN Parta 120c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Bunal 2 Cremation 3 Removal from State RUNDE CREMATOR Donation 5 Other Specify ODENTON 22. Name and Address of Facility PASADEM 2601 MOUNTAIN RO the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory alrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease a. Complications of near Drowning Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and Physician/Medical AMENDED 23a, 2/, 28a-f, per me, g931 9-11-12 sm #9perFH, g930, 8/14/2012, WS X UNPENDED The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed Records, certificate has been rector, page 2 should 24a Was an 24b. Were autopsy findings available autopsy pnor to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 🗹 Inpatient Other Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA 2 this ۵ 1 🗸 Yes 28a. Date of Injury (Month, Day,Year 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 1 Natural subject nearly drowned after 1 Yes 2 X No hours after death. within 24 hours after death To the Fuoeral Director: 7-4-12 fd 03:41 collapsing in pool 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4211 Spring Ave. Halethorpe, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 6, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris Amelia Condon Month Jul 6, 2012 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Ellicott City** Howard Morningside House If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 ☑ Months 220-12-9741 87 Hours (Month Day, Yaar) MD Director Usual Residence of Decedent 28a-f show per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Determent of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director MD **Ellicott City** Howard 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3625 Dry Creek Ct. 21043 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

General Office Manager Elementary/Seconday (0-12) College (1-4 or 5+) Managerial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Arthur Franklin Miller Roberta Elizabeth Mullineaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3625 Dry Creek Ct. Ellicott City, MD 21043 Melinda L. Magness Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Meadowridge Memorial Park, 1 Burial 2 Cremation 3 Removal from State Jul 10, 2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Nam}Stack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Se 23a. Part 1 E ter the di Ame, or complications that e used the death. shock, or heart fail do. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sudden Spontaneous Cerebral Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): anding physician and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Stroke that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 pronths?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred t medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the bay 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who co (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State o	of Maryland		artment <i>tificate</i>			and M	,	0	010	200	120
	Physicia	m/	Registrar 1. Decedent's Name (First, Middle	e, Last)	Inell Co		imouto	0, 0	Odin		2. Date of Dea		- Year	3. Time of Dea	
	Medic Examin	cal	4a. Facility Name (if not institution				4b. City, To	own, or l	Location (of Death	J	ul 15, 201	y of Death	7:55 PI	VI M
مر			Glen Burnie Hea						Glen E	Burnie			Anne	Arundel	
	Funeral Director		5. Social Security Number 408-62-9292	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. la 71	st birthday) Yrs.	If Under 1	Days :	If Under Hours	Min.	8. Date of Birth (Month, Day Aug	11, 1940	9. Birthr Coun	olace (State or Fo try) TN	reign
	and show fat	or	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation						1	Od. Inside City Li	imits
	e Maryl r 28a-f notified	Direct	MD A	nne Arundel			10f. Zip (Codo	Han	over		10g. Citizen of	M/h = A C =	1 🗆 Yes 2	No
	s 23a o	Funeral Director	169 Chesapeake M	lobile Court			101. Zip (oode	210	076		rog. Gitizen oi	U.S.		
0000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorced	Armed Formed 1 Yes If Yes, Give Year or Day	2 X No /e	1	f Yes, specif	fy Cuban	Specify:	n, Puerto F	ify Yes or No- lican, etc.)		ce - Americ ick, White, Wh	etc.	
-612	hin 72 ho ne. than "na " ne Medica	Completed		ent's Education est grade completed College (1		(Give I	lent's Usual kind of work O NOT use i	done du retired)	uring mos	t of workin	g	16b. Kind of I	Business/In	dustry	73
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Mary	2 should thand Me thand Me 27 is mark traumation		19a. Informant's Name/Relations Carol Shindledec	ship <i>(Type, Print)</i> ker Daughte	r	19b. Mailir 646	g Address (Street ar	nd Numbe ane Gl	er or Rural en Bur	Route Number	r, City or Town,	State, Zip (Code)	
saltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 177 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State 20b. Pl	lace of Dispo emetery, cren G.L. Ti	sition (Name natory or off rent Cem	e of her place n etery	9)		ate 2, 2012	20c. Location	- City or To Sneedv		
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DIVISI	tal or Atturs after de al Directo led in by t	al Certi	3 Suicide 6 Could 4 Homicide deter	28e. Place	e of Injury - At ho ing, etc. (Specify	me, farm, str	eet, factory,	office		2	28f. Location (S City or Tow		ber or Rura	l Route Number,	
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	or Notiti		29b. Signature and title of certific	//	MA		29c.	License) 3 &	number	8		29d. Date sign	ed (Month,	Day, Year)	
				19h STU	hu 200	& Cray	. No	961	Way	Su	o ble	n Bur	nie	MOHO	61
	Sta Registr		31. Date fled (Month, Day, Year), JUL 2 0 2012	Geneva 32. F	Registrar's Signat	ture		J							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:45PM 2012 IUI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt 112 MCM Baltimore NIA hen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 950 219-52-896 Director Jan Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 1 Yes 2 □ No N altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral MCMecher 21217 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗓 No Specify lack 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of thealth and Mental Hygiene. Important, if item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other tha Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare ident Be 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Surname) Mother's Name ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nise vria Kossite Baltimore, MD tro 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 19/2012 Bathmore 4 Donation 5 Dotner (Specify) 21. Signature of Funeral Service t 22. Name and Address of Facility Huneral ttorue Brehns MD Homore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ABDIOVASCUAR DISTASE attending physician and for use as the burial-transit certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical SION Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUS Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 16RBID certificate 1 Tes 2 No Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? ____1 ☐ Yes 2 ☐ No 1 Natural Certificate: To the Funeral Director: After tompleted filled in by the funera 28d. Describe how injury occurred To the Hospital or Attending 5 Pending iniury 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Lettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check з 🗆 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) WAN YWO,M 3100 Lord Baltimore Drive Ste: 108 Baltimore, MD, 21244 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July ,2012 Francis Diegelman Anthony 3:35 A M 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death
Baltimore Towson Gilchrist Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** Hours 216-20-2596 Months Days April 17,1928 Director 1X M 2 D F Yrs Usual Residence of Decedent r then "naturei", or items 23a or 28a-f show the Medical Examinar must be notified at filed within 72 hours efter death with the Maryland el Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 10028 Crane Lane USA 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cloverland Milk Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filer traent of Health end Mentel H tent: If item 27 is marked of jury or other treumetic ever ည Mary Agnes Quigley Anthony Frank Diegelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10028 Crane Lane-Baltimore, Maryland 21220 Hazel Diegelman-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of importent: If it eny injury or o Surial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other pla Parkwood Cemetery July 20, 2012 22. Name and Address of Facility
Trans Funeral Chapel and
Funeral Road-Parkvi
Transford Road-Parkvi
Transford Road-Parkvi Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee L.ME remation Services le.Maryland 21234 -andra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STROKE Jays Medical Due to (or as a consequence of): Examiner pertensin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (* as a consequence of) After this certificate has been signed by the ettending physician end funeral director, page 2 should be deteched for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 _ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month 1 Yes 2 9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 💆 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 8 JII 8300

State Registrar NI

6701

Charles

SI

Towson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES

2012

31. Date filed (Month, Day, Year)

20

MO

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wallace John Duckworth July 19, Day 2012 8:30 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Days 217-28-7662 **Director** 82 1 **X** M 2 □ F Jan.08,1930 Echart, Maryland or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Towson 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Kenilworth Park Drive Funeral Apt.2A 21204 United States death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) was Decedent Ever in U.S.
Amed Forces? U.S.Navy
14E Yes 2 No
17E Yes, Give
Year or Dates. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 hours after 1 ☐ Yes 2 HNo Specify: White 3 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 al Hygiene. Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) N/A Gas, Electric Engineer Specialist Be permit. Page 1 end 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Lawson Duckworth Carrie Eden Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mrs. Mary K. Seymour (Daughter) 1303 Summer Sweet Lane Mt. Airy, Maryland 21771 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place Evans Funeral Chapel ar Cremation Services, Inc. 20a. Method of Disposition 20c. Location - City or Town, State (Harford County) Forest Hill, Maryland Fricay, 1 Burial 2 Cremation 3 Removal from State and 4 Donation 5 Other (Specify) July 20,2012 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. OFSP Name and Address of Facility Lives Funeral and Cremation Center, P.A.

Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 Timonium, Maryland Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 1 Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. M Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) Signatura nd title of g 29c. License number 29d. Date signed (Month, Day, Year) . Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 0 2012 32. Regis State Registrar

Please Type of Print in Black Indelible Ink / Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 58AM **Physician** Son 2 0 /Medical nni 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woodlea 10006 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex Days Min Months 1 M 2 101 Yrs **Director** 213-48-5619 23, 1911 North Carolina Jun Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show items 23a or 28a-f shower must be notified at 1 Yes 2 No **Funeral Director** MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1950 Mosher Street 21217 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 ō 1 □Yes 2 🖼 No Specify: Completed by Specify 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be George McCree ဂ္ Katie Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Steele /Daughter Luray 2006 Taylor Avenue Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Semation 3 ☐ Removal from State Jul 18 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service Licenses 'n Ketter 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2201 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home Standard 6 Dother (Specify) Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 No investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (tem 23a) (Type, Print) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 1/2001

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hyllis Ann Duna		State of Maryland / Department of Heart-For State Certificate of Deartment		Reg.	No. 201	2 2300
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Phyllis Ann Dunan		2. Date of Death Month D July 17, 201	ay Year 2	3. Time of Death 1746 hrs
			r, Town, or Location of Death everly		4c. County of Death Prince George	
Funeral Director		579 52 1876 1_M 2\hat{1}F 77 Yrs. Mor	nder 1 Year If Under 24Hrs. https://doi.org/10.1001/	8. Date of Birth() October	MM/DD/YYYY) 9. Bir Poreig Co	thplace (State or on Washington DC
Aaryland 28a-f show any Lat 000ce.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Temple Hills				10d. Inside City Limits 1 Yes 2 WNo
the Mary a or 28a-	Director	10e. Street and Number 7120 Buchanan Road	Zip Code 20748	10g.	Citizen of What Coul United Sta	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at ooce	Funeral	1 Never Married 2 Married Armed Forces? If Yes, spe	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,
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vithin 72 ene.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 5 Adminis		,	P.G.County	Board of Ed.
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than event, the Medics	မှု မ	17. Father's Name (First, Middle, Last) Frank Adolphus Dunan	18.Mother's Name Fthel	(First, Middle, Maid Catherine F	,	
MD 21 id 2 should I ifth and Mer in 27 is mar numatic ev	٩	19a. Informant's Name/Relationship (Type, Print)	ss (Street and Number or R ary Court, Centro	tural Route Number	r, City or Town, State	, Zip Code)
ore, Nest and Services I and Services I and Services If item Services If item Services I and Ser		20a. Method of Disposition X Burial 2 Cremation 3 Removal from State Crematory or other place.	ame of cemetery,		Oc. Location - City or	Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: Cedar Hill C 21. Signature of Funeral Service Ligensee 22. Name ar			Suitland, N	AD 3 Old Alexandr
ळ 됩러되고 Physician	-	23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode	Road, Clinton, M	D 20/35		Approximate Interval
/Medical Examiner	i	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Uissass or injury that imitiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
and	Sal Ex	d				
60, ate be e		IF FEMALE: 23c, If yes, outcome of pregnancy		1	23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be extwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 4 Pregnant at time of death 5 Other (SA		ncy		ay Year
ires that the signed by the detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	_	co use contribute to	the cause of death?
c law requir	Completed			24a. Was an autopsy performe	prior to c death?	topsy findings available ompletion of cause of
tal Rec cian: The certificate ector, page	မ် မြ	25. Was case referred to medical	26 Place of Death (Check o		No 1 ✓ Ye	s 2 No
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ion of tending P eath. tor: After the funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Pending Investigation 28a. Date of Injury Jul (17, 2012 Pear) 1348 hrs		28d. Describe how Driver auto aut		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Roadway			et and Number or Ru) fill Road, Oxon Hill	ral Route Number, City I, MD
To the Hos within 24 hor To the Fun completely	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the core 2 Medical Examiner: On the basis of examination and/or investigation, in rand manner stated.				
F × F 3	¥		9c. License number O.C.M.E.		ed. Date signed (Monuly 18, 2012	oth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Donno M. Vinconti, MD. Assistant Modical Examinor, 900 W. P.				
Sta	ш	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Basistant Medical	anniore otreet, baitim	OIE, WID 2122	J	
Registr	213	0 0 0 1 M . M . M				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:48 A M Viola Wanda Darling 07 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days Min (Month, Day, Year) 01/24/1943 Director 216-40-0234 1 - M 2 F 69 Yrs Usual Residence of Decede 10a. State 10b. County or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2133 Hampton Court 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magangane. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemeaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Milton Kruk Josephine Manfre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Darling / Husband 2133 Hampton Court, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/20/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall 😘 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ☐ Yes 2 No cate has been signed by the i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 X No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 욛 1 Tes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) this HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending injury Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 20 on who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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19,

VIOLA DARLING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Randallstown Baltimore Northwest Hospice Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 213 20 8570 Director 1 🗆 M 2 😿 F 86 Maryland 10/01/1925 23a or 28a-f show st be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hyglene. Fant: If item 27 is marked other than "natural", or items 23siury or other traumatic event, the Medical Examiner must I ury or other traumatic event. 21224 U.S.A. 612 S. Lakewood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Ş 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Klemmick Mary Goetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Harryman 1202 Leonard Drive Glen Burnie, Maryland 21060 Important: If item 2 any Injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/17/2012 Baltimore, Maryland Bavview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to for as a consequence of [']Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate 2 No 1 Tyes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 14 No 1 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA funeral of 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury **unatural** 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and titl 29c. License number completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

ne Emken		State of Maryland / Department of Certificate of Registrar		Hygiene Reg.	No. 2012 2303
Physici dical Exam		Decedent's Name (First, Middle,Last) Blaine Emken		2. Date of Death Month D June 20, 20	3. Time of Death 12 1000 hrs
		4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Deat Bel Air		4c. County of Death Harford
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 145–78–4878 1 XX 2 F 35 Yrs.	Months Days Hours Mi		MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NJ
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati MD Harford	Forest Hil	ls	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at ouce,	Director	10e. Street and Number 1621 C Lauanne Court	10f. Zip Code 21 0 5 0		Citizen of What Country?
D Z1Z1Z1S-DU36 should be filed within 72 hours after death with the Maryland and Mental Hygiene 12 hours 1°, or items 23a or 28a-fabe '1 is marked other than "natural", or items 23a or 28a-fabe actic event, the Medical Examiner must be notified at once	by Funeral I	11. Marital Status 1 Never Married 2 Married Armed Forces? US Armty If You have a 2 No	es Decedent of Hispanic Origin? (Sees, specify Cuban, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
71 27 3-UU30 Id be filed within 72 hours a fental Hygiene. narked other than "naturs event, the Medical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Logi	nt's Usual Occupation (Give kind of lost of working life. DO NOT use re ISTICS	work done 16	Sb. Kind of Business/Industry US Army
LILIS-0030 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	17. Father's Name (First, Middle, Last) Arthur Emken			rlando
id 2 should lith and M m 27 is ma	2	Arthur Emken / Father 1316	g Address (Street and Number or 6 OpdykeAvenue,	Wanamassa	. NJ 07712
permit. Pages I and 2 should Department of Health and Me Important: If item 27 is mainjury or other traumatic en		1 Burial 2 Cremation 3 Removal from State crematory or other Specify: Brig. Gen	WM C. Doyle Vet	n. Cen.	Oc. Location - City or Town, State Wrightstown, NJ
		21. Signature of Funeral Service Licensee Victor Doda 22. N Cha 15. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	Name and Address of Facility arles L. Stevens 501 E. Fort Ave.	, Baltimo	re MD 21230
hysician /Medical xaminer	Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	n		Between Onset and Death
te be executed ysician and burial - transit	ledical E	d. MENDED AMENDED 23a,pt.II,27,28	Sm		
Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transi		past 12 months?	tal death 3 Ectopic pregn.	ancy	23d. Date of delivery Month Day Year
ires that the signed by the	þ	Part II. Other significant conditions contributing to death but not resulting in the un Cocaine Use	ınderlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
certificate has beer	Completed			24a. Was an autopsy performe	
ing Physician: The law required this certificate has been si funeral director, page 2 should the	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Paradian 28a. Date of Injury (Month, Day, Year) 28b. Time of In	njury 28c. Injury at Work?	ng Home 5 Res	
pital or Attendii ours after death. teral Director: A	Certification	Pending Investigation Suicide Homicide Homicide Pending Investigation Fd 6-16-12 Fd 1600	et, factory, office building, etc.	28f. Location (Stree	injected heroin et and Number or Rural Route Number, City) 1621 Louann Ct. 11,MD.
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		d due to the cause(s)) and manner as stated.
- s H 5	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		Od. Date signed (Month, Day, Year) une 21, 2012
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. B.	altimore Street, Baltimore,	, MD 21223	
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	U	- 1	Service .	6-	U	U	\cup	

		1- For State Cert	tificate of L	eath		Re	eg. No.	112 2303
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Albert N. Elmore, Ji	r.	<u> </u>		2. Date of Deat Month July 15, 20	Day Year	3. Time of Death 0100 hrs
		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital	4b.	City, Town, or Cherverly	Location of Death		4c. County of Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 579–98–1091		f Under 1 Yea Months Day				9. Birthplace (State or Foreign Wash. Country) D.C.
Maryland 28a-f show any d at once.	or		Fown or Location	rton				10d. Inside City Limits 1 XXYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Il Director	10e. Street and Number 234- 37th Place, S.E.		Of. Zip Code 20019			U.S.A.	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes,	specify Cubar		Rican, etc.)	White, o	Black
1036 vithin 72 hour: ene. er than "natu Medical Exan	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 11th	during most	of working life.	tion (Give kind of v . DO NOT use reti	red)	16b. Kind of Busin	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	o Be Co	17. Father's Name (First, Middle, Last) Albert N. Elmore, Sr. 19a. Informant's Name/Relationship (Type, Print) Father	40h Mailine A			oara J.	Holmar	
, MD 2 and 2 shou ealth and N em 27 is n	Ĕ	Albert N. Elmore, Sr.		37th	Place,			State, Zip Code) 20019 ity or Town, State
Baltimore, remit. Pages ar Department of Hee important: If ite		1 Burial 2 X Cremation 3 Removal from State cre	ematory or other verdale	Park Park	7/:	28/12	Riverd	dale, Md.
Physician		23a. Part I. Enter the disease, or complications that caused the death. I	1 814	Upsh	ur Stre	eet, NW	pel, Ir	20011
/Medical Examiner	-	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Blun Due to (or as a consequence of):	t Force			- Tespitatory arre	or, shock, or realt	Between Onset and Death
er ven	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
ecuted and transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		07.00		020	2 0/ 12	
3760, Ificate be executed g physician and s the burial - trans	n/Medica	X UNPENDED AMENDED 1 as not IF FEMALE: 23b. Was decedent pregnant in the	ancy	- [Ectopic pregna		23d. Date of de	elivery
Box 68 te death certifi the attending	Physician	past 12 months? 4 Pregnant at time of deat 1 Yes 2 No 9 Unknown 9 Unknown	J Other	(Specify)		incy	Month	Day Year
S, P.O.	ā	Part II. Other significant conditions contributing to death but not res	sulting in the unde	rlying cause g	iven in Part I.	1 Yes	2 ✔ No 3	te to the cause of death? Probably 4 Unknown
of Vital Records, ig Physician: The law require the this certificate has been sineral director, page 2 should b	Completed					24a. Was a autops perforr	y pric ned? dea	re autopsy findings available or to completion of cause of ath? Yes 2 No
Vital Recuysician: The this certificate	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ E	ER/Outpatient 3		of Death (Check of Other A Nursin		Residence 6	Other:
_ = . ∿ 2	Certification: 7	1 Natural 5 Pending (Month, Day, Year)	28b. Time of Injur 12:05 at ne, farm, street, f.	1 1 Y	y at Work? Yes 2 X No uilding, etc.	subject tour by 28f, Location (St	1S treet and Number	in front of or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined (Specify) stree	e, death occurred			due to the cause	(s) and manner as	
To the Ho within 24 Proceedings to the Function of the Functio	Medical	one) 2 Medical Examiner. On the basis of examination and and manner stated. 29b. Signature and title of certifier	d/or investigation,	29c. License	e number	t the time, date a	29d. Date signed	(Month, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 2:	*	O.C.N	-	are MD 045	July 15, 2012	2
St: Regist		Russell Alexander MD. Assistant Medical Examir 31. Date filed (Month, Day, Year) 12. Registrar's Signature		Dailmore	Street, Baltim	оге, МО 212	23	
DHMH 17 Rev 1/20			ORIGINAL				2	36

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State of Maryland / Department of Health and Mental Hygiene 2 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:05 pm 2012 Walter Formhalo ulu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** jarre H Mennonite rantsville Home 9. Birthplace (State or Foreign Country) | New York If Under 1 Year If Unde 8. Date of Birth 6. Sex . Age (In vrs. last birthday) **Funeral** 1 M 2 D F Month, Day Months Days Hours Min 77-14-496 9 Director 116 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 XNo Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21530 USA 891 Dorsey Hotel Road death 12. Was Decedent Ever in U.S. Armed Forces?
1 Xyes 2 No 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white "natural" Completed 3 Widowed 4 Divorced 1946 permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) rigging supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Walters Gustave Formhals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State Zin Code) 891 Dorsey Hotel Rd; Grantsville, MD Zin Code) 0 Mary Formhals - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signal re of Live ral Struic 22. Name and Address of Facility State Anatomy Board irector 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) na Medical ue to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of Exami burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached g | Hoknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed death? 1 Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 Natural iniury 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier (Check 3 🗆 To the within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Lee Bissell 124 Miller Street Grantsville, Maryland 21236 31. Date filed (Month, 2 0 2 32. Registrar State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			ental Hy	giene	2 23039
	_	_	Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Dea	atn		Reg. No. 4	
	Physicia		Allen Richmond Ferguson			2. Date of Dea Month	Day Yea	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca	ation of Death	July	19, 2012 4c. County of D	
	LXamiii	ie.	Renaissance Gardens	Silver Spi			Montgor	
Н	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	If Under 1 Year If U	Under 24 Hrs.	8. Date of Birt	th 9,	Birthplace (State or Foreign
	Director		038-09-6289 1 M 2 □ F 92 Yrs.	Months Days Ho	ours Min.	Sept. 2	y, Year) 27, 1919 Ri	node Island
	nd at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low	neation				10d. Inside City Limits
	arylar a-f sl fied	ectc	MD Montgomery Silver					1 ☐ Yes 2 ☑ No
	or 28 or 28 or oti	Ö	10e. Street and Number	10f. Zip Code			10g. Citizen of What	
	within 72 hours after death with the Maryland giene. trhan "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	3122 Gracefield Road #CT11	20904			USA	
	tems er mu	표	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spec	ify Yes or No-	14. Race - A	merican Indian,
9	fter d	b	1 Never Married 2 M Married 1 M Yes 2 No	1 Yes 2 No Sp		ican, etc.)	Diadk, W	hite, etc.
ĕ	ours a tural	Completed	Year or Dates 1942–45				Specify: Wi	nite
7	72 hd n "na Aedio	g	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during OO NOT use retired)		g	16b. Kind of Busine	ss Industry
72	vithin jiene. er tha the N	S	Elementary/Seconday (0-12) College (1-4 or 5+)	omist			Private In	ndustry
	->-	Be	17. Father's Name (First, Middle, Last)	18.	Mother's Name	(First, Middle,	Maiden Surname)	
<u>lar</u>	d be Vienta	욘	Duncan H.C. Ferguson	Ma	argaret	Allen		
lan.	shoul and I is ma			ing Address (Street and N				
≥	ind 2 lealth rm 27 her tr			Gracefield	Rd. #C	r11 Sil	ver Spring	g, MD 20904
ore	ye 1 a It of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre.	osition (Name of matory or other place)	Da	ate	20c. Location - City	or Town, State
Baltimore, Maryland 21215-0036	t. Pag tmen rtant: njury			rney Cremato			Woodbine,	
Bal	permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once.		21. Signature of Edneral Service Licensee M01651 Bell	2 Name and Address of I GOING HOME (Everly L. He	Erematic eckrotte	n Serv	ice P.O. E	Ox 784 le, MD 21029
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.					Approximate
F	nysician/	11	Immediate Cause (Final disease or condition	Failuro				Interval Between Onset and Death 2 weeks
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	rariure				2 weeks
		<u>.</u>	Sequentially list conditions, b. Arteriosclerotic	c Cardiovasc	cular Di	sease		20 years
	sit sit	Examiner	if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury) Atrial Fibrillat	L-1				20
Be	ecute and l-tran	Exa	Cause (Disease or iinjury that initiated events resulting in death) Last c. Atrial Fibrillat Due to (or as a consequence of):	LION				20 years
	be e sicial buris	dical	d					
3/6	death certificate ne attending phy: ed for use as the	Med						
χ Σ	endin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy			23d. Date of	delivery
Box	death	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			Month	Day Year
	at the	Phy	g ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	undarking apuas siyas is	Port	1		
<u>. </u>	es tha	l by	Prostate Cancer	underlying cause given in	raiti.			to the cause of death? Probably 4 □ Unknown
	requir been s	etec	Hostate Cancel					
Records,	has the page 2 s	Completed				24a. Was a autop		autopsy findings available to completion of cause of 2
ř	n: The ficate r, pag		25. Was case referred to medical			1 \(\text{Yes} \)	2 X No 1□	Yes 2 No
Vital	certii	m ,	examiner?	Other:	of Death (Check of			
6	g Phy er this eral d	e: 10	27. Manner of Death 28a. Date of injury 28b. Time o	f 28c. Injury at			lence 6 Other (Sp ow injury occurred	ecify)
0	ath. r: Afte	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident _ Investigation	work? M 1 ☐ Yes			, ,	
DIVISION	r Atte ter de recto by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	2	Bf. Location (S City or Tow	treet and Number or I	Rural Route Number,
ء َ	intal or urs affi ral Dir lled in						· · · · · · · · · · · · · · · · · · ·	4
	to the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Fundral Director. After this certificate has been signed by the attending of completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investorily one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, dea	ath occurred at the	ne time, date ar	nd place, and due to th	e cause(s) and manner stated.
:	Vithin Within To the comp.		29b. Signature and title of certifier	29c. License num			e cause(s) and manner 29d. Date signed (Mp	
			* Eileen Commell CRNA	2 R158	scole 1	'	7/19/2	2012
	11×1		30. Name and address of person who completed cause of death (Item 23a) (Type, I					
	1,		Eileen Gemmell 3160 Gracefield Rd Si	lver Spring	, MD 20	904		
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 2 0 2012 32. Registrar's Signature	•				
	- rregion e		JUL 2 V 2012 Regul A. Back	/				

			1 - For State Registrar	State of	Marylan		artment of H			giene Reg. No	L. U 1 1.	23040
•			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
	Physici		Ethol M Follo						July	Day	y Year . 2012	10:55 A M
	/Medic Examin		Ethel M. Folke 4a. Fecility Name (If not institution,		iber)		4b. City, Town, o	r Location of Deat	-	4c.	County of Deeth	10.00 A
	C.Xaiiiii	iei	Moringside Hous	20			Ellico	tt Citv			Howard	
	Funeral			6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs		th Voas		plece (State or Foreign ntry)
	Director		215-10-4675	1 M 2 F	gc	Yrs.	Months Days	Hours Min.	10/15	5/12	Ma	ryland
	P.		Usual Residence of Decedent									
	how	_	10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	Ba-f-	cto	MD Howa	ırd		E:	Llicott C	ity				1 Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	23a		5330 Dorsey Ha	11 Drive	Apt. 1	.00	210				_USA	
	r dez	Funeral	11. Marital Status	12. Was Dece	dent Ever in U. ces?	S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.))-	 Race - Ameri Black, White 	
2	or it		1 Never Married 2 Marrie	If Yes, Give	9		1 ☐ Yes 2 🔀 No	Specify:			Specify: T71.	• •
Ś	urai	d by	3. 2 Widowed 4 □ Divorced	Year or Da	ites:					1 101 10	Wn	ite
5	nat office	Completed	15. Decedent' (Specify only highes)			(Give	tent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. K	ind of Business/Ir	ndustry
Ā	then in a	d E	Elementary/Secondary (0-12)	Cotlege (1-	-4or 5+)		omemaker	1)			Home	
4	iled v tygie ther t		12 17. Father's Name (First, Middle, L			П	memaker	18 Mother's Na	me (First, Middle,	Maiden		
=	be f ad of	Be		.231/							o Sumame,	
Š	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Exertine man be notified at	To	David Tillery	to (Toron Orient)		405 84-10			line loc		Town Chair T	- C- del
0	l 2 sh and d		19a. Informant's Name/Relationsh				ng Address (Street					
n n	l and lealith im 27 ther t		Paul D. Folkeme	er / Son	20h P	1	cota Cour	t Suii	ern, New		rk 1090 ocation - City or T	
5	Pages nent of H int: if Ite		20a. Method of Disposition 1 ☐ Buriel 2. ★Cremation	3 Removal from S	D - 4	TORPET	ear Orema to	Yy	Date	200. L	ocation - City of 1	Own, State
	men tant: jury		* 4 □Donation 5 □ Other (Sp		@ I	<u>-oudon</u>			19/12			Maryland
2	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tra 2002.		21. Signature of Funeral Service L	igensee	/		. Name and Addre	. 1			Funeral 1	
_	20 E 9 0		Eugene.	y (ces	0 /		520 Wilke				Marylan	
			23a. Pert1. Enter the disease, or shock, or heart failure. List of	complications that ca only one cause on ea	used the death ach tine.	n. Do not ent	er the mode of dyin	ig, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		tmmediate Cause (Finat disease or condition		End	Stag	e Den	rentia				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence ot);						/
	Examiner		Sequentially list conditions,	b								
-	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence ot):						
	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Examiner	that initiated events	с								
,00,	an a	EX	resulting in death) Last	Due to (or as a consequ	uence of):						
0	ysici nysici he bu	dical	Ų.	d								
ŏ	ng ph	a	IF FEMALE:									
5	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pregnancy	,			23d. Date of delive	ery Day Year
	s dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregna 9☐Unkno	ant at time of de		Other (specify)			İ	MOTILIT	Day 19a1
ָ ו	w requires that the death certifit been signed by the attending p should be detached for use as	Physician/M	9 🗌 Unknown						1 0-			
ń	gned be de	by	Part II. Other significant condition	ns contributing to de	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.			. /	the cause of death?
2	en si								10	Yes 2	No 3 Pro	babły 4 Unknown
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	The harden	E							perfo	med? 2 2 No	death?	
g	sician: The lav certificate has rector, page 2	a)	25. Was case referred to medical					26. Place of De	ath (Check only o			
>	ysici is ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Ir	npatient 2	ER/Outpatier	it 3 DOA Oth	er: 4 Nursing	Home 5 ☐ Resi	dence	6 ☐ Other (Speci	fy)
5	g Ph er th ieral		27. Manner of Death	28a. Date o	of Injury h, Day Yeer)	28b. Time o	28c. Injur Wor	y at	28d. Describe	how intu	ry occurred	
5	ath. r: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		1, Day 1 60.7	прогу		Yes 2 □ No				
2	Atte	ertiflcation:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Place	of Injury - At ho	me, tarm, str	eet, tactory, office		28t. Location (City or To		nd Number or Rui	al Route Number,
5	al or	Cert	/ Individue	Donos	ig, aic. (Specif)	'')			Ony or vo	mi, Diale	2)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	3	29a. Certifier 1 Certifying	Physician: To the	best of my kno	wiedge, deat	occurred at the tir	ne, date and plac	e, and due to the	cause(s) and manner as	stated.
	n 24 n 24 n Fu	edical	(Check only 2 Medical E	xaminer: On the ba and mann		tion and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and	o place, and due	to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	te signed (Month	Dey, Year)
	6		Andres	Notes ar	MI		D.	51051		十八	1/ 19	2017
	m		30. Name and address of person v	vho completed cause	e of death (Item	23a) (Type,	Print)				1	v-12
	U		Andres Sa	lazar	362	1 41	gon Rd	Elli	Lett cir	1/1	MD:	21042

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Ford 2:29 AM VIVE 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death General N/A Maryland HOSPIta CITY Baltimore 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/10/1951 9. Birthplace (State or Foreign **Funeral** 214-56-7999 1 XM 2 - F 61 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Madison Ave. Apt 212 21217 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) y/Seconday (0-12) Grade College (1-4 or 5+) 12th Custodian Super Pride Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Ford Louise Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaTarsha Ford(daughter) 526 W. Preston St., Baltimore, MD 21201 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Kremation 3 Removal from State on-site Crematory Baltimore, MD 4 Donation 5 Other (Specify) 13/12 21. Signature of Funeral Service Licenses ²²Josephde H of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD uam MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ardiom yopath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Tetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy perform 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

Per Funeral Director; After the pleted filled in by the funeral Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.D. State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:00 PM 07 201Z Medical Phvllis Grumbine Lea 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE FRANKLIN SQUARE MEDICAL CENTER ROSEDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min Hours 216-78-8362 **Director** 1 □ M 2 🛣 F 9/23/1957 Oklahoma 54 Usual Residence of Decedent show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Maryland Middle River 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7168 Olivia Road 21220 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 K Married 72 hours after Yes 2 X No 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Specify: White Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any piury or other traumatic event, the Medical J
one. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 73 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u>Johnnie</u> Lola West Sharon Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRUMBINE Raymond Milton Grumbine (Husband) 7168 Olivia Road Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/16/2012 Bayview Crematory Baltimore, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Tecka Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LARGE INTRACRANIAL HEMCRRAGE 1 DAY disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte d be detached for in the past 12 months? Day Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TYPE I DM - CHF - CAD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? STAGE 3 CHRONIC KIDNEY DISEASE 24a. Was an has autopsy performed? Yes 2 No after death.

Director: After this certificate 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: Other: 유 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number D37612 07/11/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 9000 FRANKUN SQUARE DA, BALTIMORE, MD 21237 ALABRASH MOHAMAD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

July 19, 2012

OCME

OCME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD 31 Date filed (Month, Day, Year) Registrar's Signature ORIGINAL

30 Name and address of person who completed cause

12

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Day Physician/ 3:34 MICHAEL HICKS Jul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Colin ville 200 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Davs Hours Min. (Month, Day, NORTH 578-76-4899 55 Î 956 Director CAROLINA Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 😾 Yes 2 🗌 No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 7118 COLUMBIA PARK ROAD 20785 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

X Yes 2 No NAVY Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 🗓 No Specify: BLACK If Yes, Give Year or Dates Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working should be filed within 721 h and Mental Hygiene. **7 is marked other than** "n life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CORRECTIONAL OFFICER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAGNOLIA F. LESTER JESSE HICKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078519a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau DECARLO HICKS/SON 2330 VIRGINIA AVENUE # 302 HYATTSVILLE, MARYLAND Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mill Hill Bap. Church 07/22/2012 Roxboro, North Carolina 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No ed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been significate has been significant. Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician; in 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ಲ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after deau...
the Funeral Director: After this or ampleted filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending 1 Tes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within Z only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 20 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Day Horace Edward Hicks 201[°]2 16. 3:53 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Rockville Shady Grove Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 421-14-1062 **Director** 1 🛛 M 2 🗆 F Alabama 85 Feb. 1,1927 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified 1^X Yes 2 □ No Gaithersburg MD Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20877 20 Beane Hill Court USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 1945–46 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, , or p Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural" 3 Widowed 4 Divorced Specify: Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Government Structural Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Elizabeth K. Strother Horace Edward Hicks, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 20 Beane Hill Court Gaithersburg, MD 20877 Millard Arbutina/stepson or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 7/19/12 Woodbine, MD Signature of Juneral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death P.O. þ Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Yes 2 No 1 Yes l or Attending Physician: after death. **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 횬 1 Yes Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital thin 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certific

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 18,2012 1:10A Medical ANNIE ELIZABETH HOCK 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TIMONIUM BALTO. STELLA MARIS If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 😿 F (Month, Day, Year) 88 Director VIRGINIA 219-18-7240 3-10-1924 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. BALTO. PERRY HALL 1 ☐ Yes 2 🛣 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9601 AMBERLEIGH LANE items USA . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify. 3 ₩ Widowed 4 □ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CLERICAL BANKING 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM B. LUMPKIN HATTIE B. ELLIOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA NOTTINGHAM DTR. SHOREHAM COURT NOTTINGHAM, MD. 21236 permit. Page 1 and 3 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OAKLAWN CEMETERY 7-21-2012 BALT. MD. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME INC. mer 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) LIVER CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ANNIE HOCK
Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 No g Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? fur-eral director, Be 26. Place of Death (Check only one) Other: မ 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Aft.r this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending Investigation 2 No Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JONES, CRNP TIMONIUM, MD 21093 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, per fh, g929 7-20-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Pate of Death 3. Time of Death R. Physician/ too D lontice. MOND Medical 4a. Facility Name (frot institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Season's Hospice Randallstown Baltimore Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) (Month, Day, Year) 06/17/1951 1 M 2 □ F **Director** 214-52-9993 61 Yrs Maryland ar then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2012 Harman Avenue 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Yes Give 1 ☐ Yes 2X☐ No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) il Hygier other t Automotive Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke eny Injury or other traumatic Raymond Hood Rita Bialecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Hood / Son 1642 Brimfield Circle, Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/19/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physiclan/Medical Examine Due to (or as a consequence of) attending physician and I for use as the burial-transi Cause (Disease of injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) **To the Funeral Director:** After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No ☐ Yes 2 ☐ N 1 Yes 25. Was case referred to predical 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie 29c. License number State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 1250PM reth tolland 2012 Medical 4b. City, Facility Name (if not institution, Town, or Location of Death 4c. County of Death Examiner baltmore Ho 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. **Funeral** 1 \(\text{M} 2 \(\text{F} \) Hours Min. (MOPEN PAY 19845 CounCanada 064-38-6280 66 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Montgomery Bethesda 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 9100 Charred Oak Drive 20814 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Urban Planner Local Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Robert Adams Miriam McLeod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Holland / Husband 9100 Charred Oak Drive, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 7/19/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Primary Cardia Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) detached Unknown Unknown s been signed by the should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed After this certificate 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 2 1 I Yes 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manger of Death Medical Certificate: 28c. Injury at 28d. Describe how injury occurred iniurv Natural 5 Pending work? 24 hours after death. Funeral Director: Al 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RES-000 r I a 30. Name and address of person who confeleted cause of death (Item 23a) (Type, Print) 1860 odeans MD naton 32. Registrar's Signature State 20 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rome Huzele\	/ICN	State of Maryland / Department 1- For State Certificate Registrar			and	Menta	al Hy	_	Reg. N	20	12 230
Physici edical Exam		1. Decedent's Name (First, Middle,Last) Jerome Huzelevich					. 2	. Date of Dea Month	ath Day		3. Time of Death 2150 hrs
Julius Exami		4a. Facility Name (if not institution, give street and number)	4t	o. City, Tov	vn, or Lo	cation of I	Death	July 16, 2		4c. County of Dea	
J 17.		3625 Fairhaven Avenue		Baltimo		W.H. de e	0.411	0.0. (0)		n/a	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 217-20-7233 1X M 2 F 86	y) Yrs.	If Under Months	Days	Hours	Min.	April		Fore	irthplace (State or rign country)Maryland
		Usual Residence of Decedent						ирги	′,	1720	
1 10w any		10a. State 10b. County 10c. City, Town or Li									10d. Inside City Limits 1 X Yes 2 No
Maryland 28n-f show d at once.	Director	Maryland n/a Baltimor		10f. Zip C	ode				10g. C	itizen of What Co	
ith the Maryland 23a or 28a-f sho notified at once.		3625 Fairhaven Avenue		212	26			1	USA		
eath wit items	uneral	1 Never Married 2 Married Armed Forces?		Decedent s, specify (cify Yes or No ican, etc.)	0-	14. Race - Ame White, etc.	erican Indian, Black,
after d	by Fu	3 Widowed 4 Divorced or Divorced or Dates:	\ \ \	res 2X	No :	specify:				Specify: Wh	ite
5-0036 led within 72 hours afte Hygiene. I other thao "natural", the Medical Examiner	ted I	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)		Usual Oo st of working					16b	. Kind of Business	s/Industry
5-0036 iled within 7. Hygiene. I other thao	Completed	8 Main	nter	nance	Eng	inee	r		U	.S. Gyps	sum
FIDORE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland and of Hagane. sot: If item 27 is marked other than "natural", or items 23a or 28a-fahe or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) John Knapp				Mother's I		irst, Middle,	Maide	n Surname)	
2121 hould be fil nd Mental Is is marked atic event,	ToE	19a. Informant's Name/Relationship (Type, Print)	ailing /	Address	Street a	nd Numbe	er or Ru	ral Route Nu	mber,	City or Town, Sta	te, Zip Code)
ore, MD 3 set I and 2 show of Health and I is If item 27 is there traumatic		20a. Method of Disposition 20b. Place of Dis						Date		E , Mary La	nd 21226
Baltimore, permit. Pages 1 ar Department of Hecknown or Universe in injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory of Metro Cr	or othe	r place)							,Maryland
Baltimo permit. Page Department Important: injury or not	- 13	21 Signature of Funeral Service Licensee 120 a 12 0 er 2	22. Na	me and A	dress of	Facility	DETTE	10n -0	iet	y o Yry	and Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter									nd 21228 Approximate Interval
/Medical caminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular l						,		, , , , , , ,	Between Onset and Death
, tallillo,		or condition resulting in death) Due to (or as a consequence of):									
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause									
gg gg gg	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
So, te be executed sysician and burial - transit	Medical E	d. UNPENDED AMENDED	-								
760, icate be physicate burn	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	_						2	3d. Date of delive	ry
cords, P.O. Box 68760, as requires that the death certificate be executed thas been signed by the attending physician and a should be detached for use as the burial - transi	Physician/N	past 12 months? 4 Pregnant at time of death 5	-	I death r <i>(Specify</i>		Ectopic p	regnand	Эy		Month	Day Year
O. Bc trite dea by the a	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in t	the un	derlying ca	use nive	n in Part I		23e Did t	obacc	o use contribute t	o the cause of death?
ords, P.C w requires that is been signed be should be deta		Chronic Alcohol Abuse with Cirrhosis of the Liver		aony mig ou		or mer care					obably 4 🗹 Unknown
of Vital Records, of Physiciae: The law requinate this certificate has been sineral director, page 2 should the	Completed by							24a. Was autor			utopsy findings available completion of cause of
Rec The cate	S							1 Yes	rmed?		
Vital hysiciao this certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	tient		Ot	Death (CI			Resid	dence 6 ✓ Othe	er; Scene
ion of Vital I teoding Physiciao: sath. or: After this certifi the funeral director,		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	of Inju	· 1		at Work?		8d. Describe	how ir	njury occurred	
Division of Vital I spital or Atteoding Physiciaes: tours after death. oeral Director: After this certifi-	Certification:	2 Accident Investigation 28e, Place of Injury - At home farm	street.			2 No		8f Location (Street	and Number or R	ural Route Number, City
Division To the Hospital or Atteowithin 24 hours after death To the Rooeral Director:	Sertif	4 Homicide determined (Specify)						or Town, S		and reamber or re	arai Rode Namber, City
To the Hos within 24 h To the Fug completely	Medical (29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigations.									
To the within To the comple	Med	29b Signature and title of certifier			icense n				_	. Date signed (M	
		fle of			.C.M.	E.			Jul	ly 17, 2012	
321		30. Name address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 90	00 V	/. Baltim	ore St	treet. Ba	altimo	re, MD 21	223		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature									

DHMH 17 Rev 1/2001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 23050

		1- For State Certifi	ficate of Death		∠ U i Reg. No.	2 4 5 5 6
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Dea Month	ath Day Year	3. Time of Death
Medical Exami	ner	David Glen Harsha 4a. Facility Name (if not institution, give street and number)	I the City Town and an	July 16, 2	2012	2041 hrs
, p		1705 Ritchie Road	4b. City, Town, or Loc Upper Marlbore		4c. County of Death Prince George	
Funeral	7	Social Security Number 6. Sex 7. Age (In yrs. last to the security Number 1. Securit			rth/MM/DD/YYYYY 9. Birt	hplace (State or
Director		214-58-0676 1XM 2DF		Hours Min.	Foreig	Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City. To	wn or Location			10d. Inside City Limits
A			District Height	0		1 Yes 2 No
Aaryland 28a-f show I at once.	cto	Maryland Prince George's 10e. Street and Number	10f. Zip Code		10g. Citizen of What Cour	21
Baltimore, MD 21215-0036 Department of Heath and Mental Hygiens after death with the Maryland Oppartment of Heath and Mental Hygiens in Mental Hygiens in the Maryland important: If them 21 is marked other than "natural", or items 23a or 28a-f she niper yor other traumatic event, the Medical Examiner must be notified at once	Il Director	7410 Leona Street	2074		USA	,
death wi	uneral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify Yes or N exican, Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
after	by F	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No sp	pecify:	Specify: Wh	ite
hours natur Exam			Sa. Decedent's Usual Occupation (during most of working life. DO		16b. Kind of Business/I	ndustry
MD 21215-0036 12 should be filed within 72 hours after than do Montal Hygiens 27 is marked other than "natural", umatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Clerk		Clothing I	ndustry
15-0 iled w Hygic d other		17. Father's Name (First, Middle, Last)	_ 18.N	Nother's Name (First, Middle,	Maiden Surname)	
121 Id be I Aental narke	Be c	Corliss Harsha 19a. Informant's Name/Relationship (Type, Print)	40h Mailian Addana (O)	Rose Dryer		
S shou and N	2		19b. Mailing Address (Street and 3498 Sour Cherr			
E, N and and Health item trau		20a. Method of Disposition 20b. Place	ce of Disposition (Name of cemete	J	20c. Location - City or	
nor ages nt of nt: If other		- Monoral nom of the	matory or other place) To Crematory Inc	. 07/19/12	Baltimore,	Maryl and
Baltimore, MD 21215-00; permit. Pages I and 2 should be filled within Department of Health and Menal Hyggien. Department of Health and Annal Hyggien Important: If item 27 is marked other I injury or other traumatic event, the Med		4 Donation 5 Other Specify: Metr 21. Signature of Funeral Service Usensee Thomas Gregor				
00 8 9 1 1 1		Thomas Dua	299 Frederic	ciety Of Mary k Road Baltin	Mand, Inc. Marvla	nd 1228
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	not enter the mode of dying, such	h as cardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic	cardiovascular	Disease		Death
** p., = 1		but to (or as a consequence or).				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
Kecuted rand ransit ,	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
ਦੇ ਜ਼ਿਥ	Medical	■ MENDED AMENDED 23a,pt.II,	,27,per me,g929	7-24-12 sm		
		IF FEMALE: 23b. Was decedent pregnant in the	ncy		23d. Date of delivery	-
Box 68' e death certificate attending ed for use as	Physician	past 12 months? 1 Live birth [4 Pregnant at time of death	=	Ectopic pregnancy	Month D	ay Year
Box e death the atte ed for 1	ysi	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
that the detached		Part II. Other significant conditions contributing to death but not result	Iting in the underlying cause given	n in Part I. 23e. Did	obacco use contribute to	the cause of death?
S, P.(nires that signed d be deta	ed by	Cirrhosis of the liver, Diabete	es Mellitus	1 Ye	es 2 🗸 No 3 🗌 Prob	ably 4 Unknown
ord: w requisible been should	Completed		_	24a. Was		topsy findings available ompletion of cause of
Reco	E			1 ✓ Yes	ormed? death? 2 No 1 Ye	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?		Death (Check only one)		
'hysic hysic r this al dire	P	1 Yes 2 No No Inpatient 2 ER	NOutpatient 3 DOA		Residence 6 🗸 Other	Scene
ding 1		(Month, Day, Year)	Bb. Time of Injury 28c. Injury at		how injury occurred	
ivision or Atteno after death Director:	cati	2 Accident Investigation	1Yes			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the staffer death. The instructor: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Certification:	determined (Specific)	e, farm, street, factory, office buildi	or Town,	(Street and Number or Ru State)	ral Route Number, City
Hospi 24 hour Funer ely fil	2	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only	death occurred at the time, date a	and place, and due to the cau	se(s) and manner as state	ad
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as 1	Medical	one) 2 Medical Examiner: On the basis of examination and/o				
F * F 8	Me	29b. Signature and title of certifier	29c. License nu	imber	29d. Date signed (Mor	oth, Day, Year)
		Way.	O.C.M.E		July 17, 2012	
(A)		30. Name and address of person who completed cause of death (Item 23a	,			
70		Donna M. Vincenti, MD Assistant Medical Examin	er 900 W. Baltimore Sti	reet, Baltimore, MD 2	1223	
S Regis	tate trar	31. Date 11 (Manta Da 142) 32. Registrar s Signatur	aked			

OCME

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Edward Charles Hayes** Physician/ Month Jul 11, 2012 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Montgomery Examiner **Brooke Grove Rehabilitation** Sandy Spring 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 218-18-7572 1 X M 2 🗆 F 90 Days Hours (Mother 6, 1921 Director Usual Residence of Decedent or 28a-f shov 10b. Count 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Funeral Director MD Howard West Friendship 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a 2730 Wynfield Rd. 21794 Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 N

If Yes, Give 8/22/1942 Black, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 10/16/194 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacist 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Soterious Anastasious Hayes Pauline Lambros ပ 9a. Informant's Name/Relationship (*Type, Print*) **Pauline Hayes Garrett Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2730 Wynfield Rd. West Friendship, MD 21794 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State Crest Lawn Memorial Gardens Jul 14, 2012 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. NarStack Pureral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part in the dileam, or complications that be eschock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part Immediate Cause (Final disease or condition Physician/ Cardio vescue Atheroaclerotte Medical resulting in death) Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🖸 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation **Director:** Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

6:00 A

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗌 No

1 🗌 Yes

Year

1 Yes 2 No

Birthplace (State or Foreign Country)

U.S.A.

White

Pharmacy

24 hours

State Registrar

Medical

29a. Certifier

32. Registrar's Signature

o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

topher J. Mays, MD 18111 Prince Philip Dave, dney

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D39793

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month awyence Jeroma awK)ns 8:10 A.M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death och N/A Kaven Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Months Days 212-46-6641 Hours Min. Maryland Director 65 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3320 Ingleside Ave., 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. "natural", or þ 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 4+ years social Worker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Mae Richardson Lawrence J. Hawkins Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Hawkins(wife) 3320 Ingleside Ave., Baltimore, MD Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State on-site Creamtory 7-12-12 Baltimore, MD injury 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ððsephdd∰°Brown Jr.Funeral Home PA any 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
UM KNOWN shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ancey. Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, heding to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 Y Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 12 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Investigation Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 34359 (01110 e and address of person who completed cause of death (Item 23a) (Type, Print) Rayon Boulevard, Baltinore, Mary and 2/2/8 John 900 Lock 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

12-05242 Deoner Kendrick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 23053

		1- For State Certificate of Death			Reg.	No.	
Physicia	an/	Decedent's Name (First, Middle,Last)		N	ate of Death Month D	ay Yea	3. Time of Death 2219 hrs
ledical Exami	ner		and agation of F		ıly 11, 201	2 4c. County of	
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, of Southern Maryland Hospital Clinton	JI LOCALION OF D	Jeau		Prince G	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 2	24Hrs. 8.	Date of Birth (MM/DD/YYYY	9. Birthplace (State or
Director		240-09-8275 1 M 2KF 95 Yrs. Months Da	ays Hours	Min.	Feb. 24	,1917	Foreign North Country) Carolina
	ŀ	Usual Residence of Decedent					.30
A BUS		10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits 1 XYes 2 No
daryland 28a-f show 1 at ouce.	ğ	MD Prince Georges Upper Marlboro			1.0	0.00	
0036 within 72 hours after death with the Maryland jene. ser than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code			US	Citizen of Wh	lat Country?
ith the 23a o		9801 Healy Court 20772 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of F	dispanic Origins	2 (Specify			- American Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cub.					e, etc.
fter d		1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No	lo specify:			Specify:	Black
ours a	og pe	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup during most of working li			done 1	6b. Kind of Bu	siness/Industry
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examine	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Jeweler		,		Priv	ate
withi	E	17. Father's Name (First, Middle, Last)	18.Mother's N	Name (Firs	st, Middle, Mai	den Surname)	
	Bec	James Morgan	Salli	e Ba	ttle		
_ 2 0 9 5		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str					
ore, MD ges I and 2 sho of Health and If item 27 is ther traumati		Floyd M. Harris/Grandson 9801 Healy		r Ma:			- City or Town, State
of Her		1 Nz Burial 2 Cremation 3 Removal from State crematory or other place)					
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		4 Donation 5 Other Specify: Ft. Lincoln Ceme					ood, Maryland
Baltimo permit. Page Department Important: injury or otl		21. Signature of Funeral Service Licensee 22. Name and Addre					eral Home, Inc.
Physician	\dashv	23a. Part I. I'n er the disease, or complications that caused the death. Do not enter the mode of dyin	Landov ig, such as card	diac or res	d Hyac piratory arrest	, shock, or hea	e MD 20785 art Approximate Interval
Medical	30	failure. List only of electure on each line. Immediat Cause (Fine disease a. Asphyxia					Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):					
	ايا	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
Ne.	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or knuy that initiated c					
b sit	Examiner	events resulting in death) Last Due to (or as a consequence of):					100
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed anth. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit.		d. UNPENDED AMENDED					
760, icate be e physicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of	delivery
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Box 68' e death certifi the attending ed for use as	Physician	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown				ķ	
.O. B. hat the de ed by the letached f	돌	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I	I.	23e. Did toba	cco use contri	ibute to the cause of death?
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tal Reco		25. Was case referred to medical 26.Pla	ace of Death (Ch	heck only			V 103 2 10
Vita hysician this cer	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other ₄ N	Nursing Ho	ome 5 Re	esidence 6	Other.
ing Ph After th	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In	njury at Work?	lsuk		w injury occum	red eelchair with seatbelt
ion trendi leath. tor: /	atio	1 Natura! 5 Pending Pending Investigation Jul 11, 2012 POUND: 1 Investigation Jul 11, 2012 POUND: 2136 hrs	Yes 2 ✓ No	o aro	und neck		
Division pital or Attendir ours after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	e building, etc.			eet and Numbo te) irt, Upper Ma	er or Rural Route Number, City
D Hospital 24 hours Funeral		4 Homicide	date and place				
4 4 5	Medical	one) Medical Examiner:On the basis of examination and/or investigation, in my opini	ion, death occur	rred at the	time, date an	d place, and d	due to the cause(s)
To with	Me	and manner stated. 29b. Signature and title of certifier 29c. Lice	ense number		7	29d. Date sign	ned (Month, Day, Year)
		((yelayall) o.c	C.M.E.].	July 12, 20	112
_		30. Name and address of person who completed cause of death (Item 23a)	. 5			- -	
		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Stre	et, Baltimo	re, MD	21223		
St Regis		31, Date filed (Month, Day, Year) 111 2 0 2012 22. Registrar's Signature					
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KUSHNERICK WILLIAM

FRANKLIN SQUARE HOSPITAL ROS Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months I Days	2. Date of D Month July Location of Death	0.1	ne of Death
Physician/ Medical Examiner William John Kushnerick 4a. Facility Name (if not institution, give street and number) FRANKLIN SQUARE HOSPITAL Funeral S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months L. Dave	Month	Day Year	e of Death
Funeral 5. Social Security Number 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or FORMAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months L. Davs			30 AM.
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		4c. County of Death	
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Director 212-56-8527 1 M ⋅ 2 □ F 60 Yrs. Month's Days	If Under 24 Hrs. 8. Date of B Hours Min. (Month, E		te or Foreign
Ligual Residence of Decedent	Aug 8,		nd le City Limits
The state of the s			Yes 2 X No
TID BATTIMOTE ROSCULTS 10f. Zip Code		10g. Citizen of What Country?	
Tob. County 10a. State 10b. County 10c. City, Town or Location Rosedale 10c. Street and Number 10c. City, Town or Location Rosedale 10c. City, Town or Location 10c. City, Town or Location Rosedale 10c. City, Town or Location 10c. City, Town or Location Rosedale 10c. City, Town or Location 10c. City, Town or Location Rosedale 10c. City, Town or Location Rosedale 10c. City, Town or Location 10c. City, Town or Location Rosedale 10c. City, Town or Location 10c. City, Town or Location Rosedale		USA	
A Married 2 Married 2 Married 4 Marr	spanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian Black, White, etc. Specify: white	i,
15. Decedent's Education (Give kind of work done done) (Give kind of work done done)		16b. Kind of Business/Industry	
The state of the s	•	entertainment	c
O S S S H T T T T T T T T T T T T T T T T	18. Mother's Name (First, Middle		
Thomas John Kushnerick Thomas John Kushnerick	Betty Elizab	oeth Dean	
Due of Disposition Thomas John Kushnerick 19a. Informant's Name/Relationship (Type, Print) Cynthia Baker - sister 20a. Method of Disposition 20b. Place of Disposition (Name of	and Number or Rural Route Number Blvd; Elkhart,	ber, City or Town, State, Zip Code) Indiana 46516	
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) in State		20c. Location - City or Town, State	э
21. Signature of Frieral Service License Ronald S Nace Director 655 W. I	ss of Facility State An Baltimore St; B	altimore, MD 2120	1
shock, or heart failure. List only one cause on each line. Immediate Sause (Final disease or code Within resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): LUNG CANCER Due to (or as a consequence of): LUNG CANCER Due to (or as a consequence of):			Between and Death
Very temp of the part of the p	:y	23d. Date of delivery Month Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause gives		tobacco use contribute to the cause Yes 2 No 3 Probably 4	
The law requires age has been sign page 2 should be Completed I	per	as an 24b. Were autopsy findir prior to completion death? s 2 PNo 1 Yes 2 No	
Variable 1	ace of Death (Check only one)		
1 Mahural 5 Pending (Month, Day, Year) 1 Mahural 5 Pending (Month, Day, Year)		sidence 6 Other (Specify) e how injury occurred	-
Logical Part of the control of the c	Yes 2 No		
25. Was case referred to medical examiner? 26. Pic of the property of the		(Street and Number or Rural Route Nown, State)	umber,
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic	on, death occurred at the time, date	e and place, and due to the cause(s) and	d manner stated.
only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the policy of the policy		o the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year,	-)
MD DOT	073005	7.15.2	0/2
30. Name and address oberson who completed cause of death (Item 23a) (Type, Print) SWEATA NAGYENCOV SILIT	204 B8	dimerc MI	ca) 2123
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 5:30 PM July 14 2012 Kowalski. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7646 Stony Creek Lane Howard Ellicott City Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 XM 2 - F (Month, Day, Davs Hours 212-40-0702 70 **Director** Marvland A119 Usual Residence of Decedent shov 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d Inside City Limits Director MD Howard Ellicott City 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7646 Stony Creek Lane 21043 USA permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leon W. Kowalski Frances Lucille Drzewiecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Root (Daughter) 2301 Harvard Drive North Wales, PA 19454 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crematory 7/18/12 Glen Burnie, MD 21. Signatur- of Fun sal Service Ucersee 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP,
7250 WashingtonBlvd., Elkridge, MD 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE CORDNARY Immediate Cause (Final Physician/ SYNDROME disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). sician and burial-trans Due to (or as a consequence of). resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to the hours after death.

Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PROSTATE CANCER, SEIZURE 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) D0038296 July 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUSEAH GIBBOWS, MD 8186 LARK BROWN RD, SUITE 201, ECKRIDGE, MD 21075

MHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4	For State	State	of Marylan	•	artment of H		Mental Hyg	giene	112	23056
		Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate of D	eatn	2. Date of Dea	neg. 140. == =	1 4	
Physician Medica	/	Catherine Lo	,	ons					1/2012	Year	3. Time of Death 0730 a 4
Examine		a. Facility Name (if not institution,	•	mber)		4b. City, Town, or			4c. County		
		APEX Health Social Security Number	Care 6. Sex	7. Age (In yrs. I	ast hirthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth	Mont		ry place (State or Foreign
Funeral Director	ľ	579303811	1 ☐ M 2 🔀 F	8 3		Months Days	Hours Min.	(Month, Day	; Year)	Coun	try)
p Mo t		Usual Residence of Decedent 10a, State 10b, County		<u> </u>	y, Town or Loc	pation		10/15/	/1928	1	N C
ne Maryland or 28a-f sho notified at	2 2 2 3		0 m 0 m 11							'	1X Yes 2 □ No
the M		MD Montg 10e. Street and Number	omery	31	IVEL	Spring 10f. Zip Code	<u>.</u> .		10g. Citizen of V	Vhat Cour	itry?
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ig ig	ል	11. Marital Status 1 A Never Married 2 Marri 3 Widowed 4 Divorced	A	2 X No ve	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 【XNo	n, Mexican, Puerto		Blac	e - Americ k, White, 6 Bla	etc.
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filed w all Hygin vent, it	ᆲ	17. Father's Name (First, Middle, La	ast)					ne (First, Middle, I	Maiden Surname	e)	
ylar Jid be f Menta narked natic ev	١ ٢	Amicon Taylo			_		Lizzie	Horner	r		,
Mar 2 shou th and 27 is n traum	1	19a. Informant's Name/Relationsh			-1	g Address (Street a Sherida			-		
1 and 1 and item other	7	Gary Lyons/ 20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of	1	Date Date	20c. Location -		
altimore, rmit. Page 1 and apartment of Hea portant: If item y injury or other		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1 State He	ritag	e Memor	ialMay				f. MD
Balt permit. Depart Import any inj once.		21. Sign to of Funeral Le	Insee	2		Name and Address 425 Mary					
		23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that nly one cause on ea	caused the deat ach line.	h. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
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687 certifica nding pl	NAME OF THE PERSON OF THE PERS	F FEMALE:	23c If yes ou	tcome of pregna	incv						
Box death death e atter	iyəlcidi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	Birth 2 Feta gnant at time of c	al death 3	Ectopic pregnancy Other (specify)	y 		23d. Dat Mo	te of delive	Day Year
P.O.	ý	Part II. Other significant condition	_	death but not res	ulting in the u	nderlying cause give	en in Part I.				e cause of death?
rds,	ופח	End Stage De									pably 4 XUnknown
Records, The law require, sate has been si, page 2 should 1		Hypertension		cal De	condi	tioning		24a. Was a autop: perfor	sy p	Were autor prior to cor death?	osy findings available mpletion of cause of
in: The or, pay		Spinal Defor 25. Was case referred to medical	mity			26. Pla	ace of Death (Chec	perfor	2 No 1	I ☐ Yes	2 No
Vital hysician hysician his certifi		examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	Othe	r'	ome 5 \square Reside	ence 6 🗆 Othe	er (Specify))
on of oding Ph. Ith.: After the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investig	g .	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗆		28d. Describe ho	ow injury occurre	ed	
Division of Vital Records, all or Attending Physician: The law requires staffer cleath. Il Director After this certificate has been signed in by the funeral director, page 2 should be Contributed.		3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place	e of Injury - At ho ing, etc. (Specify		et, factory, office		28f. Location (Si City or Town		er or Rural	Route Number,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. Madical Cartificato. To Re Completed by Div.	- Calical	(Check 2 Medical Ex	caminer: On the ba	sis of examinatio	n and/or invest		n, death occurred a	at the time, date ar	nd place, and due	e to the cau	use(s) and manner stated.
To the within To the comple		only one) 3 \sqcup Certifying 29b. Signature and title of certifier	Nurse Practitione	r: To the best of r	ny knowleage,	death occurred at the			29d. Date signed		
			rowdy			D43	121		6/2	-7/1	2_
2	Ī	30. Name and address of person w NURUL CHUM 31. Date filed (Month, Pay Year)	ho complete au	se of death (Item	1 23a) (Type, P	rint)	, ,		0 1 -	7 7	
State		NURUL CHIM 31. Date filed (Month, Day, Year)	JAMEY 32. F	Registrar's Signa	605 /	wain St	, Lau	ru, m	/ 200	0.4	·
Registrar		31. Date filed (Month, Day Year)	Cleven	Ja. 140							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7/18/2012 Physician/ Steven P. Markowski Medical 5:40am 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frankford Nursing and Rehab. Baltimore Social Security Number 8. Date of Birth (Month, Day, Ye. 2/27/56 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 219-70-3238 Months Hours Country) 56 **Director** 1 XX M 2 - F MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 ☐ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 527 E. Fort Avenue 21230 USA items death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 17 is marked other than "natural", or any or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examinury or other traumatic event, and we wanted to the stanning the Medical Examinum the Medical Examinum to the stanning the second that the Medical Examinum the Medical Examinum that the Medical Examinum that the second tha 1 ☐ Yes If Yes, Give 2 **XX** Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Completed 3 Widowed 4XXDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Waterman Fishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Marion Ρ. Markowski Charlotte Α. Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte A. Markowski /MOther 527 E. Fort Avenue, Baltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If its any injury or of once. Ardent Crematory or other processing Ardent Crematory 1 Burial 2 XCremation 3 Removal from State 7/21/2012 Hanover Maryland 4 Donation 5 Other (Specify) 2. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Pheumonia disease or condition resulting in death) 6 days Medical Due to (or as a consequence of): Examiner Aspiration 6 days Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir Dysphagia -tran and vear that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Huntington's Disease 12 years the as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month Year this certificate has been signed by the arral director, page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐xNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 X No completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2XXNo Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director: After to Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **XX**atural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

24 hours a Funeral L

Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature

31. Date filed (Month, Day, Year)

and title of certifier

2 0 2012

Homand

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1714 Eutaw

32. Registrar's Signature

DHMH 17 Rev 06-2011

1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my kingwledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

67.19.12

42A Ballimore

29c. License number

N 43386

Mace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ aven 7/10/12 $4:000m^{\circ}$ Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death
Anne Arundel 4b. City, Town, or Location of Death Examiner Pasadena 706 212th Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 58 Days Min 215-70-4502 MD Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Pasadena MD 1 Yes 2 X No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ō must be Funeral **23**a USA 21122 706 212th Street items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status the Medical Examiner Armed Forces Black, White, etc. ō 1 Never Married 2 Married Yes 2 KNo ð Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. If Yes. Give Specify. White "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Virginia A. Chapman Franklin L. Thomas, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 212 Street, Pasadena MD 21122 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Melissa M. Carlton /DAughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veterans Cemetery 1XXBurial 2 Cremation 3 Removal from State injury or Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) nature . Iu . el c. . . . ensee Victor P. me and Address of Eacilly IT Les L. Stevens Funeral Home, Inc. 11 E. Fort Ave., BAltimore MD 21230 Doda any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical death certificate be Records, P.O. Box 68760 attending p IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No g Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician: The law requires 1 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 2 🗆 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending injury hin 24 hours after death. 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1)4484 7-12-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 134 pasadena MD 21122 Ritchie thry JURY ann 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MCMILLAN ONAL. 45AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HE JOHNS HOPKINS BALTIMOREC If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Social Security Number 418–80–5292 Days Min **Director** XXM2 DF 55 6/2/57 Selma, Dallas 28a-f show 10a, State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director AL Dallas Selma 1XXYes 2 ☐ No 10e Street and Number ō 10f. Zip Code r items 23a or ner must be n 10g. Citizen of What Country? 1029 East Baltimore Street Funeral 36701 USA and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Truck Driver Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked of r other traumatic ever မ L. Claudette McMillan Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 5731 River Road, #515 Santosha Goldsby /Daughter Nashville TN 37115 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1

Burlal 2

Cremation 3

Removal from State 6/23/12 Rose Hill Cemetery Beloit, Al 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 F. Fort Avenue, Baltimore MD 21230 Signature of Euneral Service Licensee Victor P. Doda Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or * a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events Due to (or as a consequence of) burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Į0 Hospital or Attending Physician; The law requires that the death in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No g Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 📝 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes death. 2 🗌 No Accident Investigation filled in by the after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 JUNE 13 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORLEANS ST BALTIMORE MD 21287 2000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month)AMES MALKINSKI JULY 2012 06:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEDSTAR HARBOR HOSPITAL BALTIMOLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 219-52-4260 **Director** 62 1 **X** M 2 □ F Yrs 11/25/49 MD Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location

Baltimore 10b. Count 10d. Inside City Limits Director MD n/a 1 XXes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1503 E. Clement Street 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Inventory Control Manufacturing marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward J. ည Malkinski Frances Prihoda and 2 should by Health and Meretem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5400 Todd Avenue, Baltimore Maryland 212 Madeline M. Leapart / Sister item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Cross Cemetery 7/19/2012 Baltimore MD 21. Signature of Funeral Service License Victor Doda 22, Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, BAltimore MD Inc. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY EMBOLISM, CAPONIC disease or condition 2 months Medical resulting in death) Due to (or as a consequence of) Examiner 3 months VENOUS THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami PANCREATIC METASTATIC and -trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Yes 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manney of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? injury within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DASAIC Viluxe 15 2012 Tullano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HAWOVERST BALTIMORE, MD LUCIANA VE 16A 21225 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

12-04750 David Scott Moffatt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physici edical Exami	an/	Decedent's Name (First, Middle, Last) David Scott Moffatt				2. Date of Death Month June 24, 20		3. Time of Death 1518 hrs
		4a. Facility Name (if not institution, give street and not 129 Deaver Street	imber)	4b. City, Town Havre de	n, or Location of Death Grace		4c. County of Death Harford	
Funeral Director		5. 20 a Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last I		Year If Under 24Hrs Days Hours Min	_	(MM/DD/YYYY) 9. Birth Foreign Cou	
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		tenul/authell, M)	so of dooth /ll 00		.C.M.E.		June 25, 2012	
		30. Name and address of person who completed cau Pamela E. Southall, MD Assistant		^{sa)} iner 900 W. Baltim	nore Street, Balti	more, MD 21	223	
S Regis	tate trar	31. Date filed (Month, Day, Year) 32.RR	egistrar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appropriate to other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	If	as Decedent of His Yes, specify Cuban	, Mexican, Puer	Specify Yes or No to Rican, etc.)	-		American Indian White, etc.	1,
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	To the Complete Compl	_	29b. Signature and title of certifier	100	A 10	29c. License n					nonth, Day, Year)	
	10		30. Name and laddress of person who co	omploted cause of death "	om 22c) (5 = - 5	K KO	2106		+	-10	12	
	W		Matasha (United Cause of death (It	em 23a) (Type, Pri	n Au	e t	558X	, M	42	1221	/
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 0 2012	32. Registrar's Sig	nature franks	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Mi Physician/ CHIVE Medical 4a. Eacility Name (if not institution, give street and number Seasons Hospice of Novinwest Hospital Alimber 16. Sex 7. Age (in yrs. last birthday) Examiner 4c. County of Death Ballmore randallstown 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 214.20.7698 Hours (Month, Day, Director 1 X M 2 □ F MD 06 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Kandallstown MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9933 21133 Circle USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Baltinore City Director of Urran Services 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Mitchner Natalie Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine WIFE) Mitchner Hoyt Circle Kandallstown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Garrison ONINGS MILL, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility C. Greene Fulleral Services aughn Valla Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, on hear failure. List only one cause in each line. Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a Insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Dause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to condeath? 2 100 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Confier (Specify, 12 TO No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 27. Manne f Death 28b. Time of 28d. Describe how injury occurred iniury M Natural 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical W certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ame and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2012 Registrar

202

CLIFFOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ In K. Moon 3.04 AM 2012 07 19 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore n/a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under : **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Months Hours 220-85-1468 **Director** 1 X M 2 □ F 82 1929 Aug. 1, South Korea Usual Residence of Decedent 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland| Howard 1 Yes 2 X No Ellicott City 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a Funeral 8934 Town and Country Blvd. Apt C 21043 South Korea 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No or. Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No If Yes, Give "natural", 3 X Widowed 4 Divorced Specify: Korean Year or Dates giene. Ser than "natura t, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Joong R. Moon Yeoi H. Choi and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Soonsue Kim / daughter 3292 Rosemary Lane West Friendship, Maryland 21794 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory,Inc. 07/19/2012 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road Baltimore Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_ician Sepsis Medical resulting in death) Due to (or as a consequence of). Examiner infection 6 days Line Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, been signal Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 **N**No ည 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No within 24 hours after death

To the Funeral Director: completely filled in by the Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Example: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 E 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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201

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32. Registrar's Signature

airlia

31. Date filed (Month, Day, Year)

2 0 2012

University

arks

Parkway

Baltimore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:00 Charlone 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNES QUEEN Anne avEER (ENTREV. 1/2 TOPPILE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 214-14-8371 **Director** 1 M 2 TF 90 July 15, 1921 Maryland Usual Residence of Deced 28a-f show 10d. Inside City Limits Oa. State 10c. City, Town or Location the Maryland notified at Director 1 Ves 2 No MD Arbutus Baltimore 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? must be Funeral 23a 21229 USA 4406 Highview Avenue items death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. Examiner Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ö þ Yes 2 X No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home the 12 Be Father's Name (First, Middle, Last) George W. Kluth 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ပ Blanche Baker traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3111 Bennett Point Road Queenstown, MD 21658 Sue Kaufman (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Dongton 5 Other (Specify) 7/14/2012 Glen Burnie, Atlantic Crematory 21. Signat of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 23a. Part 1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -,Physician/ 2 hours disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transi Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse . 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 🖬 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 K No page 2 has death? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 9 Other: 1 🗌 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) C. Ter Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury Accident
Suici 5 Pending Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UKEMS

31. Date filed (Month, Day, Year)

2540

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30,3 4:36 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silchrist Baltimore 10W SOX tospice Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country Director 1 🗆 M 2 🗓 🗗 Yrs 1940 MD 27 permit. Pega 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mantal Hyglena. Important: if item 27 is merked other then "neture!", or items 23a or 28e-f ehow amy injury or other treumetic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Nes 2 No Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 2121 SA 10°2 JOISUC Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 12 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) urse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 5mith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) May tield altimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State Southmore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility tong 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) elon Physician/ cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sete has been signad by the attending physiclan end page 2 should be deteched for use as tha burlal-trensit The law requires thet the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sav Coma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 prior to completion of cause of death?

1 Yes 2 No efter deeth. Director: After this cartificete or Attending Physicien: the funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Accident
Control
Contr Investigation 6 Could not be To the Hospitel or Atter within 24 hours efter ded To the Funerel Director completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R 31. Date filed (Month, Day, Year) 32. Registrar's signatur State

Registrar

DHMH 17 Rev 06-2011

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16b Per ANA BD G929 7/20/2012 JH State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death ^{Day}2012 Physician/ 30 8:45 AM M June Medical Margaret Orem 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Talbot. Easton 700 Port Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 2, 1920 9. Birthplace (State or Foreign **Funeral** Months New Jersey 285-12-2428 92 **Director** 1 □ M 2 🗓 F Yrs Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral with 21601 USA 700 Port St. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: "natural", Completed 3 X Widowed 4 ☐ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me own home Elementary/Secondary (0-12) College (1-4 or 5+) own home housewife 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Amelia Gertrude Davis Henry Ridley Davies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29838 Hillary Ave; Easton, MD 21601 19a. Informant's Name/Relationship (Type, Print) Thomas Orem - son t of Health other 20a Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State or Department of Important: If any injury or 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Dav Year ☐ Pregnant at time of death☐ Unknown 1 ☐ Yes 2 ☐ Unknown the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death. filled in by within 24 hours a

To the Funeral D completely

Natural

2 Accident

4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2 0 2012

5 Pending

Investigation 6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32: Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes 2 🗌 No

598 Cynwood Dr. St. 104 Easten. MD 21601

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7, per 1h, g929 7-20-12 sm

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 18, 2012 Roy E. Ostrander 11:00 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Catonsville Commons Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Sex 1X M 2 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-68-8716 JUMP PROYETS Maryland Director 57 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland items 23a or 28a-1 sno ner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 16 Fusting Ave. 21228 U.S.A. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Assistant Superintendant 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Mome Construction traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ Melen George Leroy Ostrander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 4 Little Knoll Dr. Hanover, PA. 17331 Health a Christina Ostrander - sister in law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cometery, crematory or other place.
Woodlawn Cem. July 21,2012 Woodlawn. MD. u ral rvice Licens 22. Name and Address of Facility Eckhardt. Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 21. Signature 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preamma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the control of the P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autops, performed っ ⊭ death? Chronic 1 ☐ Yes 2 ☐ No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. fnjury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) US helenih Rober de 100 Cotoror 16 MD UIL. 31. Date filed (Month, 32. Registrar's State 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pinter Frank 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 01/06/1926 **Director** 219 18 9895 1 🗶 M 2 🗆 F 86 Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Baltimore Essex 1 🗆 Yes 2 🏪 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1807 Middleborough Road 21221 United States "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Year or Dates. 1944-46 Completed 3 X Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working id Mental Hygiene. marked other than life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Sheetmetal Mechanic Aero Space Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Pinter Mary Laner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 i Christine Pierorazio (daughter) 610 Highvilla Road Essex Maryland 21221 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem Garden's 7/21/2012 Baltimore County, Md 4 Donation 5 Other (Specify) Sigr 22. Name and Address of Facility 22. Name and Address of Facility
1407 Old Eastern Avenue Essex Maryland 21221 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. Enter the disease hock, or heart failure. Li Approximate Interval Between Onset and Death Imme late Cause (Final diseas or ondition resulting in death) Stroke Physician/ Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pendina injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification le50000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore MD. 21237

DHMH 17 Rev 06-2011

Registrar

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		Territor State of Maryland / Department of Health and Mental Hygiene Control of Peath State Registrar Certificate of Death								
	Physicia	n/	Decedent's Name (First, Middle, Last)				Reg. No. 2. Date of Death Month Day Year 3. Time of Death			
, Silvery	Medic	cal	Charlotte 1. Pitce July 17 2012 4:2							
Examiner			Autumn Assisted Livin	Cockeys			4c. County of Dea Balt	imore		
	Funeral Director		212-03-9717 1 M 2 XI F 95 Yrs. Months Days Hours Min. (Month, Day, Year) Teb. 28, 1917 Maryland						thplace (State or Foreign puntry) laryland	
	and show lat	To Be Completed by Funeral Dir	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits	
	Maryl 28a-f lotifiec		Maryland Baltimore		To	owson			1 ☐ Yes 2🌠 No	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important if tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 27 Chiara Court		10f. Zip Code 2	1204	1	og Citizen of What Co United St of Amer		
			1 Never Married 2 Married 1 Yes,	ecedent Ever in U.S. I Forces? es 2XXNo Give r Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√√2No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W		
			15. Decedent's Education (Specify only highest grade completed to the completed states of the complete	ted) (16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bank Teller			16b. Kind of Business Industry Banking		
			17. Father's Name (First, Middle, Last) G. Walter Tyrie		Dan Terre	18. Mother's Nam	e (First, Middle, M lotte Zi	aiden Surname)	9	
, Mary			19a. Informant's Name/Relationship (Type, Print) George Walter Tyrie, I		Mailing Address (Street & 9026 York Ro			City or Town, State, Zi	· · · · · · · · · · · · · · · · · · ·	
imore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify)	om State 20b. Place of Evans Chape	Disposition (Name of r, crematory or other place Funeral L Rel Air	July 20	^{Day} f9, 12	20c. Location - City or Forest Hi	Town, State	
Balt	permit. Depart Import any inj		21. Signature/of Felt eral Services Licensee	Giapo	22. Name and Address Peaceful Alt 2325 York F	ematives l	Juneral and	d Cremetica (and 21093	enter, P.A.	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition								Approximate Interval Between Onset and Death		
	Medical Examiner	Ţ	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	nted d ansit	Examiner	if any, leading to immediate Due to (or as a nsequence of): cause. Enter underlying Cause (Disease or iinjury							
092	cate be executed physician and the burial-transit	edical Ex	that initiated events resulting in death) Last C. Due	to (or as a consequence of	a consequence of):					
687		n/Me		outcome of pregnancy				23d. Date of de	livery	
). Box 68	ine death of y the atter iched for u	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					Month Day Year		
ds, P.C	requires that the death certific been signed by the attending should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 → No 3 □ Probably 4 □ Unknown							
Division of Vital Records, P.O.	as 2	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of	
ita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?		_ Othe	ace of Death (Checi			Assisted	
of V	I or Attending Phys after death. Director: After this in by the funeral di	te: To	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpate of injury 28b. Tindonth, Day, Year)	me of 28c. Injury	4 □ Nursing Ho at	me 5 Resider 28d. Describe hov	nce 6 M Other (Spec v injury occurred	city) Living	
ion	or Attendin after death. Director: Aff in by the fur	Certificate:	2 Accident Investigation		M 1 Yes 2 No					
Divis	To the Hospital or Attending Physician: The k within 24 hours after death. Of the Funeral Director: After this certificate h completed filled in by the funeral director, page		4 - Horriciae determined bu	ilding, etc. (Specify)	ry - At home, farm, street, factory, office 28 . (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospita within 24 hours To the Funeral	Medical	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the within 2 To the comple	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
	1000		30. Name and address of person who completed c	ause of death (Item 23a) (Ti		32808	s, crn	07/18/5	610	
	W		6701 N. Cherles 5	f. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	05, Bal	+ mare	· MD	P130	P	
	Stat Registra		31. Date filed (Month, Day, Year) 32	Registrar's Signature	Kand					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 pay JULY 2012 FELICIA PARRISH 3:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Min. Hours (Month, Day, Year) Director 212-98-0140 1 □ M 2 🛛 F 48 Yrs MARCH 21 1964 WASHINGTON, DC Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits Director must be notified CHEVERLY 28a-f 1X Yes 2 □ No PRINCE GEORGE'S 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2812 WOODWAY PLACE 20785 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 þ 1 Never Married 2 X Married Yes Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced BLACK Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12TH PRIVATE COOK event, Department of Health and Mental H Important: If item 27 is marked on any injury or other war. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE PARRISH BARBARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2812 WOODWAY PLACE, CHEVERLY, MARYLAND 20785 BARBARA PARRISH/ MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HARMONY CEMETERY 07/21/2012 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME INC. 7474 LANDOVER ROAD, LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) **Medical** 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) o in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: al or Attending F s after death. I Director: After to in by the funer. 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 No Accident Suicide Investigation DA BRIST 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff

To the Funeral Di

completely filled in Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BABAK PIROUZ, M.D. 8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

1550

204464

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthono 2012 eonar 16 Medical Examiner 4a. Facility Name (if not in titution, give street and number) Town, or Location of Death 4c. County of Death PC Maryland OF If Under 1 Year Ut Under 24 Hrs. 5. Social Security Numbe 177–18–3462 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Min. PA Country) Hours 09/07/1923 **Director** Usual Residence of Decedent 23a or 28a-f show ist be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director PA York Fawn Grove 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral the Medical Examiner must USA 17321 913 Bridgeton Road or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?
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Yes 2 □ No Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give "natural", Specify: 3 ₩ Widowed 4 □ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Clothing Tailor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antonio Parrino Sylvia Capuano and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Janice Parrino -Daughter-in-Law 913 Bridgeton Rd., Fawn Grove, PA injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem'l Garden 7/21/12 Fallston, MD 22. Name and Address of Facility Schimunek Funeral Home 21. Signature uneral Service ticensee any 610 W. MacPhail Rd., Bel Air, MD 21014 Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ UICERS OF LOWER EXTREMETIE a. Ganage and a sequence of): Medical resulting in death) **Examiner** ALTERIOSCLEROTIE CARDIOVANO PERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ue to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events DISEASE Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: use 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death 5 Other (specify) detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Division of Vital Records, Completed 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 death? 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and Health Care 32. Registrar State

Registrar

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nneth Powell 1- For State Registrar	State of Maryland / Department of Health and Menta Certificate of Death		201	2 2307	4
	Name (First, Middle,Last)	2. Date of Death Month Day	Year	3. Time of Death 1121 hrs]

Larry Kenneth Pov		- For State	St	ate of Maryla		ertificate o			Menta	al Hyg			20	12	2307
Physician	E	Registrar 1. Decedent's Name	e (First, Middl	e.Last)		- Timeate O	Death			2	Re 2. Date of Deat	eg. No. h		3.	Time of Death
Medical Examin			KENNET								Month July 17, 20		Year		1121 hrs
7		4a. Facility Name (i 4408 Parkw		n, give street and nu Je	imber)		4b. City, To Baltim		ocation of	Death		4c. (County of De	eath	
Funeral	4	5, Social Security N	lumber	6. Sex	7. Age (In yrs.	, last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th (MM/D	D/YYYY) 9.		ace (State or
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MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. n 27 is marked uther than "natural", ur items 23s nr 28s-f shuw amatic event, the Medical Examiner must be notified at once.	ខ្ញុំ	10e. Street and Nu			Ditt		10f. Zip (Code		-	11	0g. Citize	en of What (l	
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5-0036 led within 7 Hygiene. In the Than	Completed	17. Father's Name	(First, Middle,	Last)				18	3.Mother's	Name (First, Middle, I	Maiden S	Surname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked ather than "natural", injury or other traumatic event, the Medical Examiner.	8		T GUNT						IARY I						0.1)
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/Medical Examiner	Ì	Immediate Cause (or condition resulting					lerot	ic (Cardi	ovas	scular	Disc	ase	+	Death
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Divi		4 Homicide 29a. Certifier		hysician: To the be		adge death occi	irred at the	time dat	e and plac	e and o	tue to the cau:	se(s) and	manner as	stated.	
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2	Medical Exa	miner:On the basis	of examination	and/or investiga	ation, in my	opinion,	death occ	urred at	the time, date	and plac	ce, and due	to the c	ause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ July 16, 2012 11:40 PM Frances Ryan Donna Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 022-36-9447 **Director** 1 🗆 M 2 🕱 F Jan 29, 1948 Massachusetts Usual Residence of Dece 64 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Takoma Park MD Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral and 2 should be filed within 72 hours after death with United States 20912 7117 Garland Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2X Married ģ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Education University Professor 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lorraine Ryan (unk) (unk) and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Takoma Park, MD 20912 7117 Garland Ave. Lynn Ferguson / Spouse Vicki 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or otl Page 1 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Final Journey Crematory 7/20/12 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1651 72 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_ician Medical Metastatic Ovarian Cancer disease or condition resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events as the burial-trar Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Hospital or Attending Physician; The law requires that the death Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No 1 Yes 2 X No filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Partel Jayanti 0052586 7/17 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1500 Forest Glen Rd. Jayanti Patel Silver Spring, MD 20910

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ANEND ITEM#20b, perFH, G929, 7/20/2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0 1320 M MY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death more MOYI Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth Months Hours Min. 181-28-9202 (Month Day Year) Director 1 🗆 M 2 🔂 Usual Residence of Decedent works 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f notified MD Baltimore City Baltimore 1. Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral 3922 Beech Avenue 21211 United States items 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian "natural", or ite Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify White 3 ──Widowed 4 □ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1.4 or 5+) if Health and Mental Hygiene. item 27 is marked other tha other traumatic event, the N Clothing Industry Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nikolajs Lielbriedis Nadezda Sabinina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daina Ritums /Daughter 3922 Beech Avenue Baltimore, MD 21211 t. If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 70 July 185ul 1 Burial 2 Cremation 3 Removal from State Important: It any injury of Chesapeake Crematory Beltsville, Maryland 20122012 4 ☐ Donation 5 ☐ Other (Specify) permit. . Signature of Funeral Service Licensee M01443 22. NanGazemattizoni Famid Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line.

lediate Cause (Final asse or condition assections as the cause (Final assection). Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No 2 Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) TEKLAY ompleted cause of death (Item 23a) (Type, Print) ess of person who arkwan State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	•	Cert	ificate of	Death			Reg. N	o.	16 6007
Physicia	an/	1. Decedent's Name (First, Midd				·		2. Date of I	Day	Year	3. Time of Death
Medical Exami	ner	John Colen Rya			1.4			July 11	, 2012		2115 hrs
		4a. Facility Name (if not institution 401 Granleigh Court	on, give street and number	∍r)	40	Owings N	, or Location o //ills	r Death		4c. County of De Baltimore C	
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. las	st birthday)	If Under 1		r 24Hrs. 8. Date of	Birth(M		Birthplace (State or
Director		214-68-2001	1XM 2F	57	Yrs.		ays Hours	Min	22/19	For	country) Maryland
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tua.		10a. State 10b. County		10c. City, T	own or Locatio	n					10d. Inside City Limits
and show	'n	Maryland Bal	Ltimore			Owi	ngs Mil	lls			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Cod			10g. C	itizen of What C	•
hours after death with the Maryland "natural", or items 23a or 28s-f sho Examiner must be notified at once		401 Granleigh	Court				2111	L7		United	States
h with	Funeral	11. Marital Status	12. Was Decede					in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ал White, etc	nerican Indian, Black,
r deat	핕	1 Never Married 2 M	1 Yes	2 X No							
s afte	Š	3 Widowed 4 X Div	orced If Yes, Give Year or Dates:	ompleted)		- 44	No specify:	ind of work done	16h	Specify: Kind of Busines	White
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5-0036 led within Hygiene. other tha	ខ	17. Father's Name (First, Middle	Last)	1			18.Mother's	s Name (First, Midd	e, Maide	n Surname)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	John Edward Ry					Mary	Ann Ruddy	7		
D 21 should and Me	P	19a. Informant's Name/Relations						ber or Rural Route I			
至 5 章 2 章		Robert Ryan /	Brother	1 20h PI	800 Be			O. Box 49		Location - City	MD 21120
Baltimore, M bernit. Pages Land 2 Department of Health Important: If item 2'		1 Burial 2 X Cremation	3 Removal from	State cr	ematory or other	r place)	*			Ť	
tim Pag tment rtant:		4 Donation 5 Other S	ecify:	Met	ro Crem	atory	Inc.	07/16/201	2 B	altimore	, Maryland
Baltimo permit. Page. Department o Important: injury or oth		21. Signature of Funeral Service	Alyson	K Tay	Lor 22. Na	me and Addr	ess of Facility	Cremation	1 Soc	ciety of	Maryland Land 21228
Physician	\dashv	23a. Part I. Enter the disease, or failure. List only one cause	complications that cause	ed the death. [299 not enter the	mode of dyi	ng, such as ca	rdiac or respiratory	arrest, si	hock or heart	Approximate Interval
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3760, ficate be e g physicia s the buria		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outd	ome of pregna		l doath	3 Ectopic	pregnancy	2	3d. Date of deliv Month	ery Day Year
Box 68 death certificate attending of for use as	<u>S</u> i	past 12 months?	4 Pregnant	at time of deat	<u> </u>	I death er (Specify)	o	programoy		Monar	Say Tour
Bo e deat the at	Physician		g Unknown								
	by P	Part II. Other significant condit	ions contributing to de	ath but not res	ulting in the un	derlying caus	se given in Par				to the cause of death?
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cords, law requir has been s	ple								topsy	prior t	autopsy findings available o completion of cause of
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e # ` #	<u>ë</u>	1 Natural 5 Pend	(Month, Day	,Year)	•		Yes 2 🗶			ngested	drugs
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge	, death occurre			ce, and due to the c	ause(s) a	and manner as s	
To the How within 24 h To the Fur completely	edical	one) 2 Medical Exa	miner:On the basis of ex and manner state	amination and	l/or investigatio	n, in my opin	ion, death occ	urred at the time, da	ate and p	lace, and due to	the cause(s)
F3F8	Me	29b. Signature and title of certifie				29c. Lice	nse number	<u>-</u>	29d	. Date signed (M	Month, Day, Year)
		Pot : (h	- Holler			0.0	C.M.E.		Ju	ly 12, 2012	
THERE		30. Name and address of person			•	00111 =		B	N = :	222	
O. A.	ل	Patricia Aronica-Polla				υυ W. Ba	itimore Stre	eet, Baltimore,	MD 21	223	
St Regist		31. Date filed (Month, Day, Year)	Sz. Regist	rar's Signature	e. N. S						

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Deat! 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give stree . County of Death Examiner HEALTH CARR If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 1 □ M 2 💢 F URGINIA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No 10g. Citizen of What Country? Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Yes 2 No Fyes, Give Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WhITE 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last, ٥ OHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a Department of Healt Important: If item 2 any injury or other t Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has perform 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 2 🗾 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred Director: After 1 Natural (Month, Day, Year) 5 Pending М 2 No Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1485 person who completed cause of death (Item 23a) (Type, Print)

State Registrar nse

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month rean Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death Olumbi 4 HOWA GenerA If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Funeral Months 1 M 2XX 099-38-5852 63 Director a or 28a-f show be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 X Yes 2 ☐ No 10e. Street and Number 5271 Brook Way 10f. Zip Code 10g. Citizen of What Country? ms 23a c must be Funeral 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces' ori Black, White, etc. Š 1X Never Married 2 ☐ Married XYes 2 No Maryland 21215-0036 1 Yes 2 No Specify: Yes, Give Black 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Admission Advisor Education Depart. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Issac W. SMith Lue Nette Wadley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5271 Brook Way Columbia MD 21044 Smith /Daughter Malene A. Department of Healt Important: If item 2 any injury or other t 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)

Forest Lawn Cemetery 7/7/12 Buffalo. 21. Si vature of Ly eral Service Licensee Victor P. Charles I. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LOPONALY VACULA LYENSE Physician/ Atheroderohi disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immedial cause. Enter Underlying Due to (or de a consequence o Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Fetal Geal
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown V. Mysis Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. State

W DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20,2012 Physician/ July 7:59 Sanders. Richard Lee Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore 9 Marie Avenue Essex 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 232-22-9957 1 🖂 M 2 🗆 F 93 2/19/1919 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f sho 10a. State ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 9 Marie Avenue 21221 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or ite Armed Forces?

1 XYes 2 No 1942
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. white Completed 3 X Widowed 4 □ Divorced 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) the Western Electric Corp Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental ၉ Maggie Melinda Shaver Charles Omar Sanders Richard L. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is Page 1 and 2 Severn, Maryland 21144 Rita Hemphill (Daughter) Spaulding Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition of 1 🔀 Burial 2 🗆 Cremation 3 🔲 Removal from State any injury or Meadowridge Mem Park 4 Donation 5 Other (Specify) 7/24/2012 Elkridge, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue Essex Maryland 21221 Part 1. Enter the disease, or complications shock, or heart failure. List only one cause aused the death. Do not enter the mode of dying each line. such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying **To t**he **Hospital or Attending Physician:** The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 X N 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certificate. Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 2**x** No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar DHMH 17 Rev 06-2011

3 🗆 29b. Signature and title of certif

M.D.

2 0 2012

Sanai

JUL

Date filed (Month.

30. Name and address of person (yro completed cause of death (Item 23a) (Type, Print) 6730

Baltimore,

Maryland

Holabird Avenue

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shin 10 2239 16 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat of Maryland Medical N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months June 21, 1955 215-57-1125 57 Yangin-Kun, S. Korea **Director** 1 **№** M 2 □ F or 28a-f show 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified **Lutherville** Maryland Baltimore County 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a death with 21093 S. Korea 42 Battersea Bridge Court tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin one. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Korean If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Carry-Out Restaurant Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tae Soo An Chang Hyun Shin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
42 Battersea Bridge Court Lutherville, Maryland 21093 (Wife) Mrs. Jung Ki (nee Son) Shin 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Friday, July 20,2012 20c. Location - City or Town, State (Baltinore County) Dularey Valley Metorial Cardens 4 Donation 5 Other (Specify) Timonium, Maryland 21. Signature of Funeral Service License Left rey L. Chir, Sr. O.S. 22 Name and Address Funeral and Cremation Center, P.A. air 21093-2215 Timonium, Maryland 2325 York Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death aurtic dissection Ph sician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Pregnant at time of death Month Year 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 🔲 No Accident the Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗵 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R195325 7/17/12 CRMP

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bultimore,

mp 21229

Dr

31. Date filed (Month, Day, Year) **JUL 2 0 2012**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 20:23 P homas July 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days Min. (Month, Day, Year) 20 055 Director 84 18 I1. show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2XX No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3027 Brinkley Station Drive 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black White etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify: White 3 X Widowed 4 ☐ Divorced 1952-1972 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Major Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Air Force Retired 12 Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Susan Seaton Harvey Stubbs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas A. Stubbs, Jr. (Son) 3027 Brinkley Station Drive, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2Ca. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery (LNK) Arlington Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria N101549 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or combifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause each Onset and Death Immediate Cause (Final ATION NEUMONIA Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Date to (or ear a densequence of) Cause (Disease or injury The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death ed by the ar a Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be ျှ Other: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1.X Natural 5 Pending s after death.

I Director: Af Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours To the Funeral Medical To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature nd title of certifier 8 20 MD 53885 lame and address of person who completed cause of death (Item 23a) (Type, Print) 150 32. Registrar's Signatura Date filed (Month, Day) State 2012 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Decedent's Name_(First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 1:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5913 Mardella Blvd. Prince Georges Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) 578-52-3555 **Director** 74 Usual Residence of Decedent Sept. 11, 1937 Washington, DC 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 🗆 Yes 2 🔀 No Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5913 Mardella Blvd. 20735 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Worker U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Hymes Georgia Farrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen Stevenson (Husband) 5913 Mardella Blvd. Clinton, MD 20735 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 XXCremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Lee Crematory July 19, 2012 Clinton, MD 21. Signature of Funeral Service Lice MO1555 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 m-91 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) (or as a consequence of) Examiner ap Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or injury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 month Ectopic pregnancy Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires Completed 2 No been si 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy page certificate Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours fter death.

To the Funeral cirector After completely filled in by the funer 1 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature 29d. Date signed (Month. Day, Year) 0001 30. Name and address of person who ted cause of death (Item 23a) (Type, Print) Dr. Tanika Lasien 9ay 4225 Altamont Pl. Suite 201 White Plains, MD 20695 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 19a, per fh, 2929 7-24-12 sm.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Charles Ray Strom July 11 2012 1321 М Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 309 North Seton Avenue Frederick Emmitsburg Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, 1947 1 X M 2 □ F Wisconsin 389-46-6958 65 **Director** Yrs Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Frederick **Emmitsburg** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 North Seton Avenue 21727 **USA** within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Project Manager Medical Supply 12 n and Mental Hygien is marked other t event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Menta Wallace Strom Marjorie Plant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. James Strom / Brother-22317 NE 160th, Woodinville, WA 98077 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/20/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e.g. h line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ EON rerosclerati disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transi The law requires that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ó Year 5 Other (specify) Month Day Pregnant at time of death be detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tyes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performed 2 No certificate Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? iner? Other: 2 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No the Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d, Date signed (Month, Day, Year,

State Registrar

DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Day July 20°12 9:20 Αм Ruth Ellen Semon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 219-30-5756 lal Residence of Decede 1 □ M 2 🔯 F 77 Nov 18, 1934 Maryland permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be notified at any injury or other traumatic event, the Medical Evaminar must be notified at any bines. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 211 Cedarcroft Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 No δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Genevieve Hobbs George Frederick Roeder 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
211 Cedarcroft Rd; Baltimore, MD 21212 19b. Mailing Address (Street and Number Bernard Semon - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Servige 22. Name and Address of Facility State Anatomy Board irector 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death non small cell Cancel Physician months Medical Due to (or as a con squence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) for: After this certificate has been signed by the attending physician end the funeral director, page 2 should be detached for use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗷 Other (Specify) Wo S PICE 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No м Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1) 💳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signati title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 03 2012

State Registrar

DHMH 17 Rev 06-2011

AMON

31. Date filed (Month, Day, Year)

20

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NOZVOT

of person who completed cause of death (Item 23a) (Type, Print)

M

32. Registrar's Signature

MANURS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar 1. Decedent's Name (First, Mid	ddle, Last)		Cei	artment of F			eg. No.) 2 2308		
Physicia /Medica Examine	al	4a. Facility Name (If not institu	tion, give street and numb	er)		4b. City, Town, o	Columbia		4c. County	Howard		
Funeral Director		5. Social Security Number 212-01-0729 Usual Residence of Decedent	6. Sex 7.	Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year) , 1911	9. Birthplace (State or Foreign Country) MD		
-f show fied at	tor	10a. State 10b. Cour	nty Howard	10c. City,	Town or Lo	cation	Columbia			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
rz nous arei eeali wili ine maryanu natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	10e. Street and Number 5400 Vantage Poir	nt Rd. Cedars 31	7		10f. Zip Code	21044	1	0g. Citizen of V	g. Citizen of What Country? U.S.A.		
ital Hygiene. Indocther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ا کے	11. Marital Status 1 ☐ Never Married 2 ☐ N 3 Å Widowed 4 ☐ Divorce		es? No		Was Decedent of H lf Yes, specify Cuba 1 ☐ Yes 2☐ No	lispanic Origin? (§ an, Mexican, Puer <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	Blac	e - American Indian, k, White, etc. : White		
al Hygiene. I other than "natu vent, the Medical	Completed		dent's Education thest grade completed) College (1-4 5+	or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Researc	during most of wo d) h Librarian		Library	Sb. Kind of Business/Industry Library / Transportation		
marked oth	To Be (17. Father's Name (First, Midd	Robert Kurt	z Myers			18. Mother's Na	me (First, Middle, Ruth	Maiden Surnam Naomi Ro			
27 is r trau		19a. Informant's Name/Relation Philip Stackhous	onship (Type. Print) SE SON		19b. Mailir 1022	ng Address (Street 8 Cabery Rd	and Number or R . Ellicott Ci	tural Route Numbe ty, MD 21042	r, City or Town,	State, Zip Code)		
= 능		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 □Removal from Sta r (Special)	ء ا	metery, crei	sition (Name of matory or other plac ove Cemetery		Date 21, 2012		City or Town, State Airy, Maryland		
Important: any Injury once.		21. Signature of Edheral Servi		10535	22	Name and Addre Slack Ful 3871 Old	ss of Facility neral Home, Columbia Pi	P.A. ke Ellicott Cit	y, MD 2104:	3		
ysicia he bur	ical Examiner	In mediate Cause (Final sease or condition resulting in death) Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a conseque	for	56	Per	n cu t	(a			
ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								te of delivery nth Day Year		
peo	þ	Part II. Other significant cond	ditions contributing to deat	th but not resul	ting in the u	nderlying cause giv	en in Part I.		bacco use contres 2 □ No	ribute to the cause of death? 3 ☐ Probably 4 ☐ Onknown		
age 2	Completed								sy med? 2 No	Were autopsy findings available prior to completion of cause of death?		
Director: After this in by the funeral d	Certification: To Be	3 ☐ Suicide 6 ☐ Cou	Hospital: 1 In Inp 28a. Date of (Month, estigation and the carrierd 28e. Place of the carrierd 28e.	Day Year)	28b. Time o Injury	f 28c. Injur Wor	er: 4 ☐ Nursing	Home 5 Resid	ence 6 th			
	Medical Ce		fying Physiclan: To the be cal Examiner: On the bas and manne	is of examinati								
To the	Mec	29b. Signature and title of cert		us		29c. Licens	e number	7	29d. Date signed	d (Month, Day, Year)		
Stat Registra		30. Name and address of pers 31. Date filed (Month, Day, Ye	ucky M	of death (Item	1/5	Print) (CE)	RIET	THE C	EH,	NO ZPOI		

DHMH 17 Rev 1/2001

90048600 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ July 18 Betty Jane Stapleton 12:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Hours (Month. Dav. Year) Country **Director** 212-22-8631 1 □ M 2 🔭 84 Jan. 13, 1928 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2X No Abingdon Maryland Harford 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 21009 USA 20 Boxhill South Parkway, Unit 221 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Customer (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company Service Representative Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental I ဂ္ Dorthea Elizabeth Thompson Louis Everett LeBrun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Dranmore Way, Bel Air, Maryland 21014 John LeBrun / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 7/21/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility iessea Lusaver 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Myocandial Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 2 days Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Pulmara Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 1 Yes 2 Dunknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an Was autopsy performed? prior to completion of cause of death? 2 🗌 No 1 Yes Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **N** No 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Hospital or Attending 1 🔀 Natural work?
1 Yes 5 Pending Division 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier BHATTL 118/2012 Maks WD DO074141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HAFSA BHATTI , VPPCR CHESAPEAKE MEDICAL CENTEN Th 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #24a Per PHY G929 7/20/2012 JH State of Maryland / Department of Health and Mental Hygiene 2011 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ SARR ITCKI 2012 236AM BARBARA MARY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Howard Columbia Howard County General Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-34-2527 Director 1 M 2 Tx F 07-28-1938 Maryland 73 Usual Residence of Decede 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21043 4730 Parkvale Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify. Specify: White 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Mental injury or other traumatic event. Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances T. Jakiewicz John S. Lane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23112 19a. Informant's Name/Relationship (Type, Print) Brian J. Sarnecki - son 6508-F Woodlake Village Court, Midlothian, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 07-21-2012 Baltimore, Maryland 4 Dongton 5 Other (Specify) 21. Sign Jure 9 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Funeral Service L MMP, Inc.,7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ULMONAMY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate rause Filher Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and thed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ Mo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 **N**O 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🔲 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 HOSPITT 66-Ninon 1500 MOWARD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Dea 3. Time of Dea Month Physician/ INNE Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Co. Windsor Mill Northwest If Under 1 Year If Under 24 Hrs. 5. Social Security Number 152-62-7535 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. **Director** 1 3M 2 F 04/17/1963 New Jersey 49 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Randallstown MD Baltimore CO. 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10918 Liberty Rd. 21133 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Dietician Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Page 1 and 2 should be Terrill S. Spinner Jr. other traumatic Lorene Garland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Lorene Garland(mother) 10918 Liberty Rd., Randallstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State on-site Creamtory 07/19/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Home PA Fredholms Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been siç r, page 2 should t Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate to completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Tipe, Print) 6 31. Date filed (Month Pay, Year) 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05AM 2012 Medical City, Town, or Location of Death **Examiner** 4c. County of Death DAIL MOB OB If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 | F Months (Month, Day, Yea Hours Min. **Director** MO Usual Residence of Decedent 28a-f shov 10b. County 10a. State and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-t sno ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimas 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces? Black White etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes Give Specify "natural", Completed 3 Widowed 4 Divorced ack Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Seaman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Baltimore Holloway or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Howell MID 21207 lagnts Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sta GE Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of) as the burial-trans and Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the buria or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy perform 2 No Yes 25. Was case referred to dical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

20

Daryl Thomas	State of Maryland / Department of Health and Mental Hygiene 2012230								
Physician Medical Examine		Middle Last) Thomas			2. Date of De Month July 17, 2	Day Year	3. Time of Death 0152 hrs		
	4a. Facility Name (if not ins Harbor Hospital C	titution, give street and number)		City, Town, or Location Saltimore	of Death	4c. County of Deat	h		
Funeral Director	5. Social Security Number 216-17-17-4	7 6. Sex 7. Age (In	The second second		ler 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or s Min. 03/07/1977 Foreign Country) M.D.				
any	Usual Residence of Deced	ent	City, Town or Location	10.0	1 000		10d. Inside City Limits		
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death with the Maryland or items 23s or 28s-f show must be notified at once.	10e. Street and Number	er Avenue		Of. Zip Code 21215		10g. Citizen of What Cou USA	intry?		
er death with t , or items 23s r must be not Filmeral	11. Marital Status 1 Never Married 2	12. Was Decedent Eve Armed Forces?	If Yes,	ecedent of Hispanic Ori specify Cuban, Mexicar		o- 14. Race - Amer White, etc.	ican Indian, Black,		
ural", or miner m	15 Decedent's Education	Divorced If Yes, Give Yeer or Dates: (Specify only highest grade complete)	1 Ye	s 2 No specify.	kind of work done	Specify: B	ack		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland cealth and Maryland ten 27 is marked other than "natural", or items 23a or 28a-fait traumatic event, the Medical Examiner must be notified at once To Be Completed by Firmeral Director	Elementary/Secondary (I			of working life. DO NOT		Balting.	1000		
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2121; hould be fill and Mental Is is marked title event,	1 Informan's Name/Rela	nomas Sr. ationship (Type, Fint (Morth)	er) 19b. Mailing Ad	dress (Street and Nur	hel HMA nber or Rural Route Nu	mber, City or Town, State	e, Zip Code)		
ore, MC is 1 and 2 si of Health an if item 27	20a. Method of Disposition		20b. Place of Disposition	(Name of cemetery,	nue, Bu	20c. Location - City or	10 21215 Town, State		
Page I to I to I	4 Donation 5 Oth		King Pa	rk	7/23/12		M:11:MD		
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Physician /Medical Examiner	23a. Part I. Enter the disease failure. List only one of Immediate Cause (Final dis	0		ode of dying, such as o	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death		
<u> L</u> Xaiiiiiei	or condition resulting in dea								
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying C (Disease or injury that initia	ause	ence of):						
ecuted and transit transit	events resulting in death) I		ence of):						
be expurisal		AMENDED 23c. If yes, outcome of	foregnancy			22d Date of deliver			
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of Vital Records, P.O. Bo) ing Physician: The law requires that the dealt After this certificate has been signed by the att inneral director, page 2 should be detached for mr. To Be Completed by Physi	Part II. Other significant co	Unknown 9 Unknown	- Galer		art I. 23e. Did t	obacco use contribute to	the cause of death?		
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Records, The law requires fricate has been signed; page 2 should be						psy prior to o primed? death?	topsy findings available completion of cause of		
Ital Reletan: The certificat rector, pag				26.Place of Death	(Check only one)	2 No 1 ✓ Ye	es 2 No		
f Vit Physici or this c	examiner? 1 V Yes 2 No 27. Manner of Death		2 ER/Outpatient 3		Nursing Home 5		r:		
	1 Natural 5	Pending Investigation 28a. Date of Injury Jul 17, 2012	28b. Time of Injury 0126 hrs	28c. Injury at Work 1 Yes 2 ✓	Subject she	how injury occurred ot			
Divis oltal or A urs after A illed in b	3 Suicide 6 4 Homicide	Could not be determined (Specify) Local S	- At home, farm, street, fa Street	ctory, office building, et	or Town.	Street and Number or Ru State) f 6th Street, Baltimore			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificampletely filled in by the funeral director, Medical Certification: To Be C		ng Physician: To the best of my kno Examiner:On the basis of examinal and manner stated.							
F S F S D	29b Signature and title of co			29c. License number		29d. Date signed (Mor	nth, Day, Year)		
Ou	touil.	-tolle	(lb-= 02c)	O.C.M.E.		July 17, 2012			
00	Patricia Aronica-P		cal Examiner 900) W. Baltimore Str	reet, Baltimore, M	D 21223			
State Registra		012 Senera S.	gnature						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Month Year annie 7:50 AM DY Medical 4b. City Town, or Localed BALTI (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death HOSP GNES MORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 1 🗆 M 2 🔀 81 or items 23a or 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director Baltimore 1 Yes 2 No 10e. Street and lumb 10f. Zin Code 10g. Citizen of What Country? 21229 ane 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or any hijury or other traumatic event, the Medical Examit 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupatio (Give kind of work done durin 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOTuse retired) Secondary (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, ပ prence 9a. Informant's Nar Relationship (T e. Print) 21229 20a. Method of Disposition Burial 2 Cremation 3 Removal from State cemetery, cremat any injury o 4 Donation 5 Other (Specify) 21. Signature of Fune a Service Licensee L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-trail that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 No 1 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director; At completely filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check completed cause of death (Item 23a) (Type, Print) Kehman 200 aton

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 327 Medical Examiner 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death NA 67 naryland Hospital Grenera ocial Security Number **Funeral** . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 215-60-3283 Director 1 XM 2 = F Yrs -16-195 60 28a-f show 10a, State notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a Silverthorne Ruad 21239 WSA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner. 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Un LAD UNE (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry NA (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) "larence years Be 17. Father's Name (First, Middle, Last) WhiL 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence Son Road Randallstown, MD 21133 E. Terry Jr. Shen ton Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place + Z10n Cemet 1 Durial 2 Cremation 3 Removal from State Lansdown, MD 4 Donation 5 Other (Specify) 7-21-2012 emeter 21. Signature of Funeral Service Licenses 22. Name and Address of acility Avenue Bulto. MD 21202 6 110 · North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy inian orona disease or condition Medical resulting in death) Due to (or as a consulence of) Examiner Sequentially list conditions, if my backing to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a nonsequence of): physician and s the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral clirector, page 2 should be detached for use as the burn completely filled in by the funeral clirector, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Heart Failure performed? Yes 2 X No ongestrue 2 No 1 Yes Be 25. Was a e referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 7/13/2012 ne and address of person who completed cause of death (Item 23a) (Type, Print) maryland Gieneral 31. Date filed (Month, Day, Year) State 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18. Day Physician/ July 2012^a 6:45 p M Burke Teather Phyllis J. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Arm Baltimore 2 Manor Springs Court If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Director 219-32-4398 1 □ M 2 🕱 F Yrs Sept. 22, 1934 New York 77 Usual Residence of Decedent or 28a-f show notified at show 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 21057 United States 2 Manor Springs Court Was Deceus. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Specify: "natural" 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore County Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot rother traumatic ever ٩ Catherine Helen Shaughnessy t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke njury or other traumatic Francis Nelson Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Manor Springs Court, Glen Arm, Maryland 21057 Ronald T. Teather (Husband) Baltimore, 20a. Method of Disposition

1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department or Important: If any injury or Metro Crematory, Inc. 7/19/2012 Catonsville, MD ourg of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of MD 299 Frederick Road, Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions ner Due to (or esta nonsequence of) if any, leading to himed cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the the attending IF FEMALE: 23c. If yes, outcome of pregnancy

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1 Yes 2 No Pregnant at time of death 9 Unknow g | Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsv perform 2 X No 1 Yes 2 No Yes 24 hours area com... Funeral Director: After this cerumos Filand in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗶 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d, Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, usaur occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. 29b. Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Charles 6569 N. Swite 20 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Damon Christian Venia Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Deat Emergena Queen Anne Queenstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 6/28/78 If Under Birthplace (State or Foreign Country) **Funeral** Social Security Number 464–43–5689 **Director** 1**25**M 2 □ F TΥ 28a-f show 10a. State ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Oueen Annes Queenstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Somerset Ct. 21658 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ Never Married 2 Married ☐ Yes 2 XXVo Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Retail 12 Data Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Anthony Ogden Cynthia Anne Rose permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Anthony Ogden/Father 111 Somerset Ct, Queenstown MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State 7/6/12 4 Donation 5 Other (Specify) Laurel Oaks Memorial Park Mesauite Signature of Fune al Service Licensee Victor Doda 22. Name and Address of Facility **Charles L. Stevens Funeral Home, Inc** Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to for as a consectionox of cause. Enter Underlying Cause (Disease or injury that initiated events Examin Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Yes 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending after death. 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Thomas Wright em 23a) (Type, Print) Shoreway Drive Oucens town, MD 21658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALSH 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JC. Physician/ Month JULV 2012 William 6:57 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton 6809 Crofton Colony Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days Director 250-42-2168 1 🕅 M 2 🗆 F Yrs Aug 23, 1930 Massachusetts Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland in than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Crofton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21114 6809 Crofton Colony Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Caucasian If Yes Give 3 Divorced Completed Year or Dates. Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Department of Energy parmit. Page 1 end 2 should be filed with Depertment of Heelth and Mentel Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the once. 5+ Nuclear Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Henrietta Sward William Rudolph Voigt, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, MD 21114 6809 Crofton Colony Ct. Julian P. Voigt / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 7/19/12 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Foneral Service Licensee Going Home Cremation Service P.O. Box 784 MO1651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ YPars ase or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Funaral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use as the burlel-transi Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 🗌 No within 24 hours after death. To the Funarai Director: Af 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of cert

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of

31. Date filed (Month, Day, Year)

2 0 2012

2003 Medical Perferien Sute 300 Amazolis

MI

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

			ricase i	State of Maryland / Dep			e	
			1 - State Registrar		rtificate of Death	Reg. N		23097
	Physicia /Medic		1. Decedent's Name (First, Middle) Last)	how WINGE	C		ay Year 9 2012	3. Time of Death
	Examin		4a Fecility-Name (It not institution, give.	street and number	4b City Town, or Location of Death	4	c. County of Death	
	Funeral Director	0	110-00-1011	TM 2 F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign out)
Maryland	f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation Wilti			10d. Inside City Limits 1
death with the Maryland	3a or 28a- at be notif	Funeral Director	10e. Street and Number (FN to	AVE.	10f. Zip Code 21/202	10g. C	Citizen of What Cou	intry?
	ital Hygiene. id other than "natural", or Items 23a or 28a-f show event, If a Medical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 PYes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Bleck, White Specify:	
. U	Hygiene. Ither than "natur ont, It a Medical I	Completed	15. Decedent's Edu (Specify only highest grad	cation (Give Completed)	edent's Usual Occupation e kind of work dope during most of work po NOT use refined)	EACE C	Kind of Business/I	NORF
yland ,	nd Mental Hygiene. marked other than matic event, it a Me	To Be C	17. Father's Name (First, Middle, Last)	vdeic ,	18 Mother's Name	(First, Middle, Maide	NEV	>
e, Mar	it of Health and Men If Item 27 Is marke or other traumatic		19a Informant's Name/Relationship T	in when 90	ing Address (Street and Number for Run Societion (Name of	Al Rouge Number, City	WALTO.	own, State
	rtent rtent njury		1 ☐ Burial 2 ☐ Cfernation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Service Licens	Removal from State	22, Name and Address of Facility	5/2 / / SEPH (5)	Altimo	NE CEY.
D ed	Depa Impo sny ii		Cythia C	F. LUNVISCU !	302 N, CENHUL	AVE B	97-60. MO	Approximate
	ysician Medical		shock, I heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not en ne cause on each line. a. Due to (or as a consequence of):	Carcinom	e		Interval Between Onset and Death
	aminer	ier	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	a Lung			1 year
ate be executed	nysician and he burial-transit	icai Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				100
O. BOX 68/ he death certificate	been signed by the attending phys should be detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
uires that th	signed by Id be detac	by P		ntributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
VITAL RECORDS, P.O.	te has beer age 2 shou	Completed	Hysertons	m hogyl-tail	u Al	24a. Was an autopsy performed?	prior to c death?	topsy findings available ompletion of cause of
	certifica rector, p	o Be C	25. Was case referred to medical examiner?	Hospital:	Other	(Check only one)		
On Or	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	H	1 Pes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2 ER/Outpatie 28b. Time Injury	ant 3 DOA 4 Nursing Ho	28d. Describe how in		ary)
UIVISION el or Attending	s after dea I Director of in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
ne Hospit	n 24 hour ne Funere sletely fille	edical (sician: To the best of my knowledge, dea ner: On the basis of examination and/or and manner stated.				
Toth	To the comp	Me	29b. Signature and title of certifier	Nh2	29c License number D 2 Lb Lt 9	29d. [Tu	Cy 20	2012
	\		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type AS KARAN 3 45.	5 Wilkens Art	Baltime	N MD	21229
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 0 2012	32. Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ William Weinkam Wieman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Ritchie House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 54 213 76 9655 Director 1 AM 2 D F 06/10/1958 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21221 317 N. Marlyn Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married چ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Auto Repair Mechanic 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Bramble Α. Husted Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 317 N. Marlyn Avenue Essex Maryland 21221 Frederick W. Weinkam (brother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 N Donation 5 Other (Specify) Holly Hill Mem Gardens 7/24/2012 Baltimore Co., Maryland ure at Funeral Service Licens 22. Name and Address of Facility 21. Sign Bruzdzinski Fun eral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 at caused the death. To find enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1 Enter the disease, nock or heart failure. Li only one cause Immurate Truse (Final Physician/ condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Division of Vital Records, P.O. Box 68760 Cus Wanthan Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The lew requires that the death certificate E within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the I IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day NIGNER 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🖟 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) -18-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2012

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Thomas J. Winiecki Physician/ July 18, 2012 1:30 PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1021 S. Kenwood Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours 1276671929 218-22-5367 82 Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ¥ Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 1021 S. Kenwood Avenue 21224 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Year or Dates Korea 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Ship Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Thomas Winiecki Gertrude Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Winiecki - Wife 1021 S. Kenwood Avenue Paltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Saint Stanislaus
Cemetery 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/21/2012 Baltimore, Maryland 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, 21. Signature of Funeral Service Licence Maryland 21231 ry 1. Enter the disease, or commencations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 12 Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and -transit Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed viphrea that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed been signated 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2: autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural n 24 hours area he Funeral Director; Aft work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0055 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add BASTIAN JOIAN 3023

W DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici Medical Exami		Decedent's Name (First, Middle,Last) Tale					Date of Deat Month	th Day Year	3. Time of Death		
Medicai Exami	ner	Khamhou Xairavong 4a. Facility Name (if not institution, give st	reet and number)		h City Town	or Location of Dea	Month July 17, 20	4c. County of Deal	0720 hrs		
		Bush River	reet and number)		Aberdeen	or Eccation of Dea	u i	Harford			
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye		_	th (MM/DD/YYYY) 9. Bi			
Director		351-72-1669 1XM Usual Residence of Decedent	2 F	35 Yrs.	Months Da	ys Hours Mi	July 1		ountry) Laos		
any		10a. State 10b. County	10c. City	, Town or Location	on				10d. Inside City Limits		
Aaryland 28a-f show 1 at once.	P	Maryland Harford	Ed	dgewood					1 Yes 2 No		
Maryli 28a-f d at o	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Cod									
ith the Maryland 23a or 28a-f sho notified at once		608 Sorrelwood Co			21040			USA			
eath w items	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces?			lispanic Origin? (\$ an, Mexican, Puert		- 14. Race - Ame White, etc.	rican Indian, Black,		
ufter d	by Ft	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: As									
nours ? natura		15. Decedent's Education (Specify only h	nighest grade completed)			ation (Give kind of e. DO NOT use re		16b. Kind of Business	/Industry		
36 in 72 in dical I	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		_			Antomotics	Donain		
od with	Com	17. Father's Name (First, Middle, Last)	<u>T</u>	Mecha	штс	18.Mother's Nam	e (First, Middle, N	Automotive	: кератт		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Be	Kideng Xairavong				Chanhou	ıan Sank	vilode			
Should nd Me	٩	19a. Informant's Name/Relationship (Type	•	1	•			nber, City or Town, Stat			
my MD and 2 she ealth and tem 27 is traumati		Debbie Xairavong / 20a. Method of Disposition		Place of Disposit			Date	wood, Maryl 20c. Location - City o			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 Burial 2 Cremation 3	Temoval itom otate	crematory or oth		7.	21 2012				
Iltim nit. Pa artmer sortan	1	4 Donation 5 Other Specify: 21. Signature of Funeral Sertice leicensee		se Hill	SVCS. I			Bel Air, Funeral Hom			
E Per Co		Hiller K. Miller	nas	13	317 Coke			ngdon, Mary			
Physician /Medi		23a. Part I. Enter the disease, or complicate failure. List only one cause on each I		. Do not enter th	e mode of dyin	g, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
Examiner			rowning to (or as a consequence of	of).					Death		
g3		Sequentially list conditions, b.	to to as a consequence of	,,,.							
- :	niner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of	of):							
red nsit	Examiner	events resulting in death) Last	to (or as a consequence of	of):							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	d. X UNPENDED X A	MENDED 23a, 27, 2 1 as not	8a-f,pe	r me,go	7-24- 7-26-12	12 sm				
760, icate be physicate burn			3c. If yes, outcome of preg	nancy				23d. Date of deliver	·		
Box 687 death certific he attending p	cian	past 12 months?	Live birth Pregnant at time of de	ath -	al death 3 er (Specify)	Ectopic pregr	ancy	Month	Day Year		
BO; le deatl the att	Physician/		Unknown					I			
ires that the signed by I be detache	by P	Part II. Other significant conditions col	ntributing to death but not r	esulting in the ur	nderlying cause	given in Part I.		bacco use contribute to 2 No 3 Pro			
ds, equires een sig	sted						24a. Was a		utopsy findings available		
e law r e has b ge 2 sh	Completed						autop: perfor	med? death?	completion of cause of		
Division of Vital Records, salor Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should it	ပိ	25. Was case referred to medical			26.Pla	e of Death (Check	1 Yes	2 No 1 Y	es 2 No		
Vita hysicia this ce	OB	examiner? 1 ✔ Yes 2 No	oital: 1 npatient 2	ER/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence 6 🗸 Othe	er: Scene		
J Of Jing Pt After funeral	L:uc	27. Manner of Death 1 Natural 5 Deading	28a. Date of Injury (Month, Day,Year)	28b. Time of In	jury 28c. In	ury at Work?		now injury occurred drowned in	river		
Siol Atten r death ector: by the	cati	2 Accident 5 Pending Investigation	fd 7-17-12 28e. Place of Injury - At h	fd 6:50		Yes 2 X No			ural Route Number, City		
Div	Certification	3 Suicide 6 Could not be determined		d in riv	•	banang, o.c.		tate) Bush Riv (
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician:	To the best of my knowled	lge, death occurr	ed at the time,		d due to the caus	e(s) and manner as sta			
To the within To the compl	Medical	an	the basis of examination a d manner stated.	and/or investigation			at the time, date				
	2	29b. Signature and title of certifier	200			.M.E.		29d. Date signed (Mo	ontn, Day, Year)		
		30. Name and address of person who com	oleted cause of death (Item	1 23a)			<u>.</u>	July 17, 2012			
Roand		Patricia Aronica-Pollak MD.	Assistant Medical		900 W. Balt	imore Street,	Baltimore, MI	D 21223			
St Regis		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	barks							
veil 2	لنند	JUL ~ V LVIL X	the party	LA CA							

12-05369 Robert Zellmer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 23101

oben Zeilmer		1- For State	tate of Maryland		cate of Dea		ntai Hygiene	Reg. No		
Physicia ledical Examir	ın/	Registrar 1. Decedent's Name (First, Midd Robert Joseph				-	2. Date of Month July 17			3. Time of Death 1212 hrs
		4a. Facility Name (if not instituti Franklin Square Hos				, Town, or Location edale	of Death	4	c. County of Dea Baltimore Co	
Funeral Director		5. Social Security Number 212–48–9860	6. Sex 7. Ag	e (In yrs. last b	oirthday) If Ur Mon Yrs.		1.0	f Birth (MM • 10, 1	Foro	irthplace (State or ign Baltinore, MD. ountry)
эм апу		Usual Residence of Decedent 10a. State 10b. County	N/A		on or Location					10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	않	Maryland 10e. Street and Number 3200 Echodale		Ба		ip Code 21214	<u> </u>		tizen of What Co	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked ofter than "natural", or items 23a or 28a-fabl injury or other traumatic event, the Medical Examiner must be notified at once	Funeral D	11. Marital Status 1 Never Married 2 X	12. Was Decedent			dent of Hispanic Or	rigin? (Specify Yes o n, Puerto Rican, etc.)		14. Race - Ame White, etc.	rican Indian, Black,
hours after of natural", o	ব্র	15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade con	npleted) 16a	a. Decedent's Usua	No specifical Occupation (Give orking life, DO NO	kind of work done	16b.	Specify: WI Kind of Business AT &	
21215-0036 ould be filed within 72 hours a: 1 Mental Hygiene, s marked other than "natural ite event, the Medical Examin	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle	01	5+)	Proj	ect Manag	Jer er's Name (First, Midd	le Maider	Interna	tional
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To Be	Joseph A. Zelli 19a. Informant's Name/Relation	Mer ship (Type, Print) W11			Gert	crude Anne	Rudo	ly	e, Zip Code)
re, MD I and 2 sho Health and fitem 27 is	-	Mrs.Bonnie Cyn: 20a. Method of Disposition 1 Burial 2 Crematio	•	20b. Place	of Disposition (N	ame of cemetery,	chodale Ave	20c.		Town State County)
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		4 Donation 5 Other S 21. Signature of Funeral Service	Leffrey L.	air,Sr.C	FS 22. Name ar	Address of Facili	Friday, July 20,20	12 Fo	orest Hi.	ll,Maryland
Physician /Medical		23/ Part I/Ente/the disease, of failure. List only one cause	complications that caused on each line.	the death. Do	not enter the mode	of dying, such as	4.186.2011.111	JVETVI	ann Ziir	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		tic Cardiovasc	ular Disease				Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consect. C. Due to (or as a consect.)		-					
executed in and il - transit	Sal Ex	events resulting in death) Last UNPENDED	dAMENDED							
		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 23c. If yes, outcom 1 Live birth 4 Pregnant at	ne of pregnanc	y 2 Fetal deatl 5 Other (Sp		ic pregnancy	23	d. Date of deliver	ry Day Year
trihe of ached	by Phys	Part II. Other significant condi	tions contributing to death	n but not resulti	ing in the underlying	ng cause given in P		_		the cause of death?
cords law requ	Completed						24a. W	as an atopsy erformed?	24b. Were a	utopsy findings available completion of cause of
tal Rection: The certificate ector, page	Be Co	25. Was case referred to medica examiner?		u		26.Place of Death	1 🗸 Ye	es 2 N	lo 1	es 2 No
n of Vit ding Physic After this	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie	nt 2 🗹 ER/0	Outpatient 3	DOA Other 2	Nursing Home 5 k? 28d. Descri		ence 6 Othe	er.
tendii eath.	Certification:	2 Accident Inve	ding estigation		farm, street, factor	1 Yes 2 y, office building, e	etc. 28f. Locatio		and Number or R	ural Route Number, City
		4 Homicide dete	(Specify) Thysician: To the best of my	/ knowledge, de	eath occurred at the	e time, date and p		n, State) ause(s) ar	nd manner as sta	ted
To the within 2 To the complet	Medical	(Gridat Grif)	aminer: On the basis of exar and manner stated.	_	investigation, in n		ccurred at the time, d	ate and pla		ne cause(s)
KW		Colsis	MA	de	7	O.C.M.E.			y 18, 2012	·
12 11			Assistant Medical Ex	aminer 9		ore Street, Ball	imore, MD 2122	3		
Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrat	's Signature	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ UROTIMI emi Wowal Medical Name (if not institution, give street and number County of Death **Examiner** eton pper ince 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral Director** hicago, I or 28a-f shov 10b items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location Director 1 Yes 2 No per 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20 within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc 1 Never Married 2 Married "natural", or 9 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ode olashade 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, HNOWale Upper Marlboro 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 W Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 9013 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran: that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed this certificate 2 🗌 No Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Joiely 063748 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PowderMill Rd Beltsville Koy Atchou

Registrar DHMH 17 Rev 06-2011

State

4041

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death June June Physician/ 40 A M inde Medical 4a. Facility Name (if not institution, give street and number) Examiner Baltimore ton rest taven Nursing Home g. Birthplace (State or Foreign Country)

DC Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days Hours 07/04/1953 579-72-3703 58 1 🛛 M 2 🗆 F **Director** 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Examiner must be notified at Director Washington DC none 1X Yes 2 ☐ No 10f. Zip Code 10a. Citizen of What Country? 0 10e. Street and Number U.S.A "natural", or items 23a Funeral 20011 1301 Upshur Street, NE #206 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? þ 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of the alth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify. Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Unemployed 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gloria C. Scott Unknown g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimi Gray Ct.,SE Washington, DC 20019 19a. Informant's Name/Relationship (Type, Print) Gloria S. Scott (Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery crematory or other place)
Lincoln Memorial 1 XBurial 2 Cremation 3 Removal from State 07/03/2012 Suitland, Md. 4 Donation 5 Other (Specify) CC0530 22. Name and Address of Facility Signature of Funeral Service Licensee Latney's Funeral Home 3831 Georgia Ave., NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the at a Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death' þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has a completely filled in by the funeral director, page 2 s. autopsy nerform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Tyes 2 11No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniurv 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Taymon Mule mo 29 D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWINSS Po Box Mills 21117 Raymond Miller 1525 31. Date filed (Month, Day, Year) Registrar's Signature State 05 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Month Physician/ 8:05 Joanalee Angeline Armes Julv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Svkesville Transitions Healthcare at Sykesville Carroll If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 🗆 M 2 💢 F Months 439-48-8862 Director 1935 Guam Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Tes 2 X No MD Carroll Svkesville 10e. Street and Number 10g. Citizen of What Country? Funeral 7309 2nd Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced 1955-85 Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Armv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nichols Kordick Phebe Gawne th. Page 1 and 2 shous. 19a. Informant's Name/Relationship (Type, Print) Wardian of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Property Esquire Katherine L. Taylor, 5850 Waterloo Road, #140, Columbia, MD 21045 Department of Healt Important: If item 2 any injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition $Julv^{Date}6.$ 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Licenses 812 Funderson Services, P.A. - Coli Michael MD 20853 4110 Aspen Hill Road, #100, Rockville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Year Other (specify) Pregnant at time of death been signed by the a should be detached t g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy after death.

Director: After this certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Hospital ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1/2 Natural injury 5 Pending 2 No Accident Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my information and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MD westminstr MALMOUD 1737 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 State Registrar Certificate of Death 2. Date of Death Time of Death Physician/ 50 ITON 807 M ora Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** en-1825 -nollwood Millersville Anno Arunde uano If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** (Month, Day 1 🗆 M 2 🗶 F Hours 83 **Director** 1928 Alabama 256-38-6933 Aug. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD 1 2 Yes 2 No Prince George's Bowie 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a USA 2714 Advent Ct. South 20716 items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ith and Mental H 27 is marked of traumatic ever မ Annie Robinson J.W. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac Shirley B. Phillips / Daughter 2714 Advent Ct. South Bowie, MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 7/3/2012 Baltimore, MD 4 Donation 5 Other (Specify) Beall Funeral Home . Signature of Pup 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 20715 part 1. Enter the disase shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Immediate Cause (F) al Onset and Death Physician/ disease or condition-Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Isigned by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn After this certificate I 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes Accident Investigation □ Accider
 □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) F12153891 3/17 Jennifer H. Clark of death (Item 23a) (Type, Print) Jennifer H.
Who is the first the control of the State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6/30/12 Day Pablo Flores Blanco 6:30 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Pay, Year) 7/8/1939 Hours **Director** 216-87-0425 Usual Residence of Decedent 1 X M 2 🗆 F 72 Yrs El Salvador ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince Georges Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2308 Erskine Street 20783 Salvador items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No o. Black, White, etc. <u></u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", 1 X Yes 2 □ No Specify: Salvadorian Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 7 is marked o of Health and Mental fitem 27 is marked of 2 Heudenio Torres Blanco Ermila Flores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francisco Flores-son 4601 Barbara Dr., Beltsville, MD 20705 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Maryland Nat'l 7/7/12 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home Wanda Baion CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) **Examiner** Multi organ failure Sequentially list conditions, in any leading to improve cause. Enter Underlying Date to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury Sepsis that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Gastrointestinal bleeding Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been sig should t Acute Renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Diabetes Melitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No ည 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending within 24 hours ofter death.

To the Funeral Circctor Afti
completely filled in by the fur work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nirsy Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Sirak Lemma

0 5 2012

31. Date filed (Month, Day, Year)

D65069

1500 Forest Glen Road Silver Spring, MD 20917

7/2/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G930 8/28/2012 JH State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hilda Bartlett June Physician/ 3:49 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince _aure| George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) 10/05/1919 92 Yrs. Director 134-26-8614 1 □ M 2**X** F Nassau Bahamas Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10d. Inside City Limits Director D/C none Washington 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 938 "P" Funeral Street, NW 20001 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Self-Employed Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Be 17. Father's Name (First, Middle, Last) 18. Regaria Firamidal Badde tree Burrows ပ Robert Bartlett Ann Vanotte Burrows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alec L. Bullard(Grandson) Street, NW Washington, DC 20001 "P" 938 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Fort Lincoln 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/05/2012 4 Donation 5 Other (Specify) Brentwood, Md. 22. Name and Address of Facility CC0530 Latney's Funeral Home 3831 Georgia Ave., NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ poxid disease or condition Medical resulting in death) Due t (o as a consequence of) **Examiner** Kidney cute Sequentially list conditions, if any, leading to innecessate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Respiratory Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death
Unknown Year detached been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be HyperKalemia 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ※ No 24a. Was an To the most safer death.

To the Eneral Director. After this certificate has I with the service of the service Hospital or Attending Physician: The law autopsy performed Yes 2 Division of Vital Completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Medical Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06-26-2012 D12962 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital Lorayda Lee-Llacer, MD 2070 Laurel 31. Date filed (Month, Day, Year) State 05 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 23B & 25, PER MD G929 7/31/12 TRT
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Day Anniebell Brown 6:47 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Social Security Number 8. Date of Birth
2-28-1922 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 579-32-8611 90 **Director** 1 🗆 M 2 🛛 F Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD PG Upper Marlboro 1 🗌 Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9415 Fairhaven Ave. 20772 U.S.A. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 X Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Phillips Easter Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20772$ Department of Health an Important: If item 27 is any injury or other trauonce. Shirly Brown (Daughter) 9415 Fairhaven Ave. Upper Marlboro MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 7-11-2012 Brentwood MD. Fort Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensed

Frances B. Hunt 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St. N.W. Wash, D.C. CC353 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cordionimonary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 10000 Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed News for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ementia 1 Yes 2 No 3 Probably 4 Unknown Completed peen Fluid Overload Disorder 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes , 2 🛣 No 24a. Was an page 2 s autopsy perform Malignant 24 hours after death.

Funeral Director. After this certificate letely filled in by the funeral director, pag Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 2 Accident
3 Suicide Investigation 6 \square Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hound to the second 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ျ Techooly D0052865 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Ficars MO, 20769 12150 Annapolis Ra, Ste 200 Glann Dale, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 06

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ - Month 1012 JULY Vivian E. Bogley 2:25 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Reeder's Memorial Nursing Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Hours Min 0972971912 Country) Director 99 213-44-5300 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Frederick Frederick 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 5955 Quinn Orchard Rd. #220 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. crossing guard Board of Education Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BOGLET James. Broadhurst Artie Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Clemons/daughter 172 Hickory Lane, Bumpass, VA 23024 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 07/07/2012 | Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CENGESTIVE HETER FAILURE STAGE OND disease or condition resulting in death) Manth Medical Due to (or as a consequence of) Examine KNAL SIMME months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed DEBILIT months that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death detached 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ᢂ No 24a. Was an has director, page 2 autopsy certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural injury 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar egistrar's Signature

BOONSBORD, MARYLAND

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L 0 5 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		Decedent's Name (First, Middle, I	_ast)					2. Date of De	eath		3. Time of Death
Physicia Medic		Kenneth Jos	eph	Brown	1			June	2 2 Day	2 0 1 2	7:45 AM
Examin	er	4a. Facility Name (if not institution, g					Location of Death	1		County of Death	
Funeral	-	Crescent Citi 5. Social Security Number 6	. Sex	7. Age (In yrs. I		Riverd If Under 1 Year	lale I If Under 24 Hrs.	8. Date of Bi		ince Ge	place (State or Foreign
Director		200-14-7589	1 🔀 M 2 🗆 F	8 7	Yrs.	Months Days	Hours Min.	Month, D. 5 / 1 5	^{ay} 192	5 Pen	nsylvania
how	ř	Usual Residence of Decedent 10a. State 10b. County	_	10c. Cit	y, Town or Loc	eation					10d. Inside City Limits
, Ba-f s tified	Director	Md. Prince	George	s F	ort Wa	ashingt	o n				1 🎇 Yes 2 🗆 No
a or 2 be no	٥	10e, Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
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or itel niner	by Fu	11. Marital Status1 ☐ Never Married 2	Armed For		I1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerte	pecify Yes or No- po Rican, etc.)	· 1	4. Race - Ameri Black, White,	
ıral", I Exar		3 Widowed 4 Divorced	If Yes, Give Year or Da	e	1	☐ Yes 2 🛣 No	Specify:		S	Specify: B1a	ck
"natu edica	Completed	15. Decedent' (Specify only highest	s Education grade completed)		(Give k	ent's Usual Occup ind of work done o		king	16b. Kir	nd of Business Ir	dustry
r thar	Con	Elementary/Seconday (0-12)	College (1-	,	Engi	neer			Loca	1 Gove	rnment
al Hyg d othe vent,	Be	17. Father's Name (First, Middle, Las					18. Mother's Nar			urname)	
Menta narked natic e	မ	Lesly Brown					Mary S	aunder	S		
traum		19a. Informant's Name/Relationship			1	g Address (Street a					
f Healt item 2 other		Linda Brown-B 20a. Method of Disposition	usn/Daug	20b. F	Place of Dispos	sition (Name of		Date Wa		cation - City or T	Md . 20744 own, State
int: If		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				natory or other plac e Park		26/2012	1	zerdale	
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic				. Name and Addres	ss of Facility B 1	uford	Fune	eral Se	ervice
6 # 교조.	Щ	Church D	Buja							Vash.,	DC 20020
ysician/ Medical xaminer		23a. Part 1. Enter the disease, or conshock, or heart failure. List only limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	y one cause on ea a. <u>A+++</u>		leve	the Car				ease	Approximate Interval Between Onset and Death
□ .@	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C	or as a consequ							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Birth 2 D Feta nant at time of c	al death 3 📃	Ectopic pregnanc Other (specify)	у		2	3d. Date of deliv	ery Day Year
e deta	by P	Part II. Other significant conditions									he cause of death?
een siç ould b		Dysnhap	1 WI	W	1354	cho si	5	1 🗆	Yes 2]No 3 ☐ Pro	bably 4 Unknown
has be e 2 sh	Completed	bysnhap	M					24a. Was	psy		psy findings available impletion of cause of
ficate or, pag		25. Was case referred to medical				ac Di			ormed? 2 No	1 Yes	2 No
s certi	To Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗆	EB/Outpatien	Othe	ace of Death (Chec		dence 6	Other (Specify	-
ter thi		27. Manner of Death 1 Natural 5 □ Pending	28a. Date		28b. Time of injury	28c. Injury work	at at	28d. Describe			
leath. tor: Af the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	tion			M 1 🗆	Yes 2 No				
after o		4 □ Homicide determin	28e. Place	of Injury - At ho ng, etc. <i>(Specify</i>		et, factory, office		28f. Location (City or To		Number or Rura	l Route Number,
n 24 hours ie Funeral oleted filled	Medical	(Check 2 L Medical Exa	hysician: To the beaminer: On the bas turne Practioner: 1	s of examination	n and/or investi	gation, in my opinio	n, death occurred	at the time, date	and place, a	and due to the ca	use(s) and manner stated
withi		29b. Signature and title of certifier	2 12.	2 -	, (29c. License				signed (Month,	
4		Dull		/re			852	- 1	_	= 25 2	
By 1		30. Name and address of person when Paul A-Po	o completed caus	e of death (Item	123a) (Type, P	veeasb	ury, Red	Hyau	Esta	e Mus	20781
Stat Registra	e Ir	30. Name and address of person when Paul A - Post	2012 3 Re	egistrar's Signat	9. pa	Ne I					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Albert Ritchie Cox, Sr. Physician/ $\operatorname{JuMPe}^{\operatorname{th}}$ 30°, 2012° 2:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bradford Oaks Clinton Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Da 220-16-5103 85 Director 1**XX**M 2 □ F 11/28/1926 Washington, DC Usual Residence of Decedent show 10d. Inside City Limits aţ 10b. County 10c. City. Town or Location Director ems 23a or 28a-f sh r must be notified a 1 Yes 2XXNo Marvland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 72 hours after death with 11509 Marv Catherine Drive 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White, etc. 1 Never Married 2XX Married ρ 1XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White Specify 'natural", 3 Divorced 4 Divorced WW II Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Governemnt event, the Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Arthur Cox Cecelia Anna Mudd I and 2 should be I Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Teresa Cox / Wife 11509 Mary Catherine Drive Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or o 1 X Burial 2 Cremation 3 Removal from State y's Ch. Cem. 07/06/2012 Clinton, Marvland
22. Name and Address of Facility George P. Kalas Funeral Home, P. . . 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Ch. Cem. 21. Sign July Funeral Service Licen 6160 Oxon Hill Rd., Oxon Hill, MD. 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Ducito for as a consequence of Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death
Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? To the Hospital or Attending Physician: The ☐ Yes 2 ☐ No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ZXIX No 4XX Nursing Home 5 Residence 6 Other (Specify) 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ..end. ...er death. ..al Director: After injury 1 X Natural 5 Pending 1 Yes 2 No __ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of ce who completed cause of death (Item 23a) (Type, Print) Kau£man, M.D. 12070 Old Line Centre #207 Waldorf, MD 20602 Louis V. 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 05 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Day 2012 Pear July Elizabeth Conlan 4:05 PM Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick
Social Security Number Memorial Frederick Frederick Hospital Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) **Director** 076-28-4332 1 🗆 M 2 🔀 F 78 Oct. 16, 1933 New York Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 K No Maryland Frederick Middletown 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? must be Funeral 23a 105 Ivy Hill Drive 21769 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked of Cornelius O'Callaghan Margaret McDonough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ivy Hill Drive, Middletown, Maryland 21769 Maura Brown / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Garden State Crematory 7/7/2012 4 ☐ Donation 5 ☐ Other (Specify) North Bergen, NJ 21. Signatus Funeral S 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner years obstructive palmonary chronic Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of,. years Cause (Disease or injury Aorha stenosis that initiated events resulting in death) Last Due to (or as a consequence of) attending physician years Certificate: To Be Completed by Physician/Medical Congestive heart failure To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Pregnant at time of death Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitui Dinbetes 2 No 3 Probably 4 Unknown Carolid sknosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Matural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 171319 July 2, 2012 Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol Waldmann Mp 400 west I'm street Frederik, Maryland 21701 31. Date filed (Month, Day, Year) State 5 20

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7/3/2012 Physician/ 7:15 AM CHARLOTTE CRAFTON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES BRADFORD OAKS NURSING HOME CLINTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Days Hours Min. Director 240-56-8557 1 □ M 2 💢 F Yrs NORTH CAROLINA 8/14/1933 78 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No HYATTSVILLE 1ARYLAND PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20784 4804 STOCKTON LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 X Widowed 4 ☐ Divorced Completed BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HEALTH CARE HOME HEALTH CARE permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GARNELL TORRENCE OTHO WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 STOCKTON LANE, HYATTSVILLE, MD 20784 LAYTANA BACON/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESA PEAKE CREMATION 7/5/2012 STEVENSVILLE, MD CENTER 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS IELFENBEIN & NEWNAM CREMATION & FUNERAL CARE 21. Signature of Funeral Service Licensee 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VAScerlan everyn Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Pregnant at time of death 5 ☐ Other (specify) g Unknown 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nusse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Well (anne D31206 2012 30. Name and altidress of person who completed cause of death (Item 23a) (Type, Print) Grint) Griff Road Fort WASHington unaryland TANNER MO linn 11701 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day HARRY MONROE JULY 2012 0:13 CRAMER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Hours Min 212-24-3063 87 Director 1 **X** M 2 □ F 11/07/1924 Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No MD Frederick Frederick 10e Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 12 E. 13th Street 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc ò þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White "natural", Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) milk processing Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the plant 12 delivery driver of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emory K. Cramer Grace Ramsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Cramer / son 89 S. Main St., Keedysville, MD 21756 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State .o. ∓.ro Department of Important: If any injury or once, 7/4/2012 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 MO1222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betyleen Onset and beath shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician thed for use as the buris Physician/Medical certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day be detached g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autonsv perform Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Manner of Doubth Date of injury (Month, Day, Year) 28c. Injury at work? e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and the control of the pasts of examination and the control of the cont 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Costifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 06-2011 29b. Signature ar

31. Date filed (Month, Day, Ye

Dr. Robert Kaufmann /

Year) 5

act 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Exercas

300 W. 9th St., Frederick, MD 21701

29d. Date signed (Month, Day, Year)

12-04742		
Remard Coatley	.lr	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

S	tate	e o	fΙ	Mary	land /	De _l	partm	ent o	of He	alth a	and	Mental	Hygiene

2012 23			1
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			- For State Certificate of Death	Reg. No	D.	
Phys Medical Exa		an/		2. Date of Death Month Day June 24, 2012	Year	3. Time of Death 0406 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Chevlery		tc. County of Death Prince George	
Fune Direct			5. Social Security Number 220 - 94 - 1857 6. Sex 1 Months Days Hours Min.	8. Date of Birth(MN 05/07/1	972 Foreign	
and show any			Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 X Yes 2 No
the Maryland	be notified at once,	Dire	10e. Street and Number 5601 Parker House Terr 20782		itizen of What Coun SA	try?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "aatural", or items 23a or 28a-fah	must	by Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Yes 2 No 3 Widowed 4 Divorced or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No specify:	Rican, etc.)	14. Race - Americ White, etc. Specify: B1a	ack
21215-0036 Uld be filed within 72 hours after Mental Hygiene. marked other than "natural",	fedical Exam	npleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Kind of Business/Ir Private	Ť	
21215-0036 21216-wild be filed within 7 Mental Hygiene. marked other than	vent, the N	Be	Bernard S. Coatley Sr. Barbar	First, Middle, Maide a C. Jac	ckson	
MD 21 id 2 should ! lith and Mer	aumatic c	2	19a. Informant's Name/Relationship (Type, Print) Barbara C. Coatley-El mother 19b. Mailing Address (Street and Number or Research House)		20	782
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is in	ry or other traumatie		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	12012 B	Location - City or eltsvil	le, MD
			21. Signature of Funeral Service Licensee MO1388 Wesley Chayi Wounkirk, MD. 20 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			4 Southers Blvd. Approximate Interval
Physicia Examin	al		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	,		Between Onset and Death
	ı	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
red 1	ansit	Examiner	C. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
), oe executed ician and	the burial - transit	Medical	UNPENDED AMENDED			
68760, ertificate bo	e as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		3d. Date of delivery Month D	ay Year
Box 687 e death certific the attending	ned for use as the	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
P.O.	be detach	à	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to t No 3 Prob	he cause of death? ably 4 Unknown
ords, ** require s been si	houl	Completed		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
of Vital Recoing Physician: The law After this certificate has	page 2	S		performed? 1 ✓ Yes 2		2 No
/ital sician:	director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 4 Nursing		dence 6 Other:	
		-	27. Manner of Death 28a. Date of Injury (Month Day Year) 1	28d. Describe how in Driver of motor \		in collision
Divisi ital or Att urs after de ral Direct	filled in by the	Certification:	3 Suicide 6 Could not be	28f. Location (Street or Town, State) 1200 block of Balti		al Route Number, City e Park, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	completely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
To To To	3	¥	29b. Signature and title of certifier 29c. License number O.C.M.E.		I. Date signed (Monne 24, 2012	th, Day, Year)
100		}	30. Name and address of person who completed cause of death (Item 23a)			
60			Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Ba	altimore, MD 21	223	
Re	St gist	ate rar	31. Date filed (Month, Day Keer) 12012 Server S. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $J_{\mathbf{u}}^{\mathsf{Month}}$ Physician/ 2012 Year Audrev Jane Denison 9:26 РΜ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Bowie Bowie Health Center Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 044-26-8522 77 1 🗆 M 2 🏋 F **Director** Feb. 2. 1935 Connecticut Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20715 2814 Birdseye Lane within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No <u>8</u> Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Ernestine Jacobs John Swain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Bowie, MD 2814 Birdseye Lane, 20715 Nelson C. Denison / Spouse Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 7/7/2012 Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition arten Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last burialthe attending physician the for use as the buria Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Records, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 116 Decense Highway Annapolis, 31. Date filed (Month, Day, Year gistrar's Signature 05 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William F. Donaldson, Sr. July 2012 6:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Hospice House 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 216-18-5939 88 Director 13€34M 2 □ F Feb. 6, 1924 Maryland fshov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Millersville Anne Arundel Maryland 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 700 Doages Drive 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XXYes 2 ☐ No If Yes, Give 7.7 ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2XX No Specify: Specify. 3 X Widowed 4 Divorced WW II Completed Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Contracting Building Contractor 8 ofth and Mental Hygie 27 is marked other r traumatic event, t Be filed 17. Father's Name (First, Middle, Last)
Ulysses Grant Donaldson, Jr. 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be fill of Health and Mental If item 27 is marked or other traumatic even ပ Mary Sterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3742 Thomas Point Road Annapolis, Maryland 21403 William Donaldson, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ţ 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or <u>+</u> 5 Cedar Bluff Cemetery : 7/7/2012 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final End Stage Chronic Lung Disease Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and the for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CVA, Dementia, Hypertension 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Hos ice House funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this of Autorial Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No М 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 3, 2012 D21438 a mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, MD 445 Defense Highway Annapolis, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month 7 / 2 / 1/2 Physician/ Maria Laura Martinez de Galicia 21:00 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 19942 **Director** 220-47-1133 1 □ M 2 🔀 F El Salvador Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12325 New Hampshire Avenue 20904 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ρ 1 Never Married 2 X Married Maryland 21215-0036 1 x Yes 2 □ No Specify: Salvadorian Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Babysitter Domestic permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sebastian Martinez Felicita Jesus Rosales 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zoila Martinez Machuca 6303 Eunice Ave., Baltimore, MD 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 igstyle Burial 2 igstyle Cremation 3 igstyle Removal from StateFamily Cemetery 7/9/12 El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home CC0361 bacon Wanda C. 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sudden Immediate Cause (Final Physician/ Hypotension disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Kidney Disease Stage IV years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial tansi Diabetes Mellitus, Type II Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 SS IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Cther (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year the Unknown 9 XUnknown signed by to Part II. **Other signifi⊏ant ⊏onditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð sepsis Completed 1 Yes 2 No 3 Probably 4 No Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 this certificate has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital ၉ 1 Yes 2 No Other: 1 XInpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completely filled in by the fu 1 🗌 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

5/2

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Κ.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gupta,

29c. License number

MD 9801 Georgia Ave., ste 220 Silver Spring, MD 20902

D32332

29d. Date signed (Month, Day, Year)

7/3/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DORSEY June 2012 5:58 AM GENEVIEVE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick <u>Frederick Memorial</u> Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director 218-38-1006 1 □ M 2 🕱 F March 2, 1921 Maryland Maryland Usual Residence of Decede or 28a-f show notified at 10a, State 10c. City, Town or Location death with the Maryland Director 1X Yes 2 No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ral", or items 23a or Examiner must be r Funeral 800 Motter Avenue Apt. 21702 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed **Black** Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gertrude Unkown William McSwain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Biggus/ Daughter 6010 Bartonsville Road, Frederick, Maryland 21704 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 0 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o New London Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2012 New Market, Maryland Signa ur Funeral Service 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown any Home P. A. Pike, Frederick, Maryland 21702 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part 1, Enter the disease, or complic shock, or heart failure. List only one Interval Between Onset and Death tonser Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner emento Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) ō in the past 12 months? Month Year Day 1 L Yes 2 = 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ oine Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 **I**No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) hin 24 hours after death.

the Funeral Director: After this

mpletely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complet 29b. Signature and title of certifier MDD 0054636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 THY 31 Date filed (Month. 0 5 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 30 2012 VICTORIA DAVIS JUNE 6:05 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **HYATTSVILLE** ST. THOMAS MORE NURSING HOME If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Yrs. Director 102-48-2264 8-11-1954 HARLEM, NY Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No MD PG LARGO Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1023 DREXELGATE LANE 20774 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2█No Specify Specify: BLACK Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT 12TH EXECUTIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ပ VIRGINIA KING 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE M. DAVIS/DAUGHTER 1023 DREXELGATE LANE, LARGO, MD 20774 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Cemetery, crematory or other place)
MARYLAND VETERANS
CEMETERY AT CHELTENHAM 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -16-2012 CHELTENHAM, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Lice 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 11901085 RUX 23a. Partf. Enjer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCIENTIC (ANDIOVASCULA DILECTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loaning to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending property for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown م signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Renal Distaso / Hemodralysis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Dubett Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has I autopsy certificate 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No r this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours at er death.

To the Funeral Director A
completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Arcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D01852 JUNE 302012 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DEVOREMB 4203 Queens bory Rel Hyatts. He MD 20181 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygi	ene		00101			
			Registrar	rtificate of Death	T	eg. No. 2	12	23 2			
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Elva E.T. Estry		Date of Death Month	30 ^{Day} 201	Year	3. Time of Death			
	Medic		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death				6:05 A M			
	Examin	ier	5821 63rd. Ave.	Riverdale		4c. County of Death Prince Georg		roe's			
	* Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		g. Birthpl	ace (State or Foreign			
	Director		215-36-4881 1 □ M 2 🖾 F 93 Yrs.	Months Days Hours Min.	July 31,	1918	New S	ersey			
	d tow	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation			140	d. Inside City Limits			
	arylar a-f sk fied a	[왕						1 X Yes 2 No			
	he Ma or 28,	Ē	Md. Prince George's Riverda	10f. Zip Code	10	Og. Citizen of W	/hat Count				
	with t 23a st be	eral	5821 63rd. Ave.	20737			S.A.	<i>y</i> .			
	leath items er mi	Funeral Director		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race	- America				
36	", or i	by	1 Never Married 2 Married 1 Yes 2 X No	1 ☐ Yes 2 🖾 No Specify:	nican, etc.)	Specify:	k, White, et				
Ö	ours a stural	Completed	3 🗆 Vildowed 4 🖎 Divorced Year or Dates.				Whi				
<u> </u>	72 h an "na Medic	mpf	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work O NOT use retired)	ing	16b. Kind of Bus	siness Indu	istry			
21215-0036	withir giene er tha the		Elementary/Seconday (U-12) College (1-4 or 5+)	istered Nurse		Nui	rsing				
b	filed all Hy d oth	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname))				
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	은	Unknown	Nellie	Reich	ard					
ã Na	shol			ng Address (Street and Number or Rura							
e,	and Healt		George Estry/Son 1050 20a. Method of Disposition 20b. Place of Dispo	O3 Taryn Court, Mit		le, Md.					
no	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crei	natory or other place)			•				
Baltimore,	permit. Page Department of Important: If any injury or once.		Olidai Del	Crematory 7-2-2		Riverda					
m	Imp Der		MA Chameet M00091	Name and Address of Facility Chambers Funeral F 5801 Cleveland Ave	lome & Cr e. River	ematori dale. M	ium,P Ad. 2	.A. 0737			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.					Approximate nterval Between			
7	Ph sician/		Immediate Cause (Final disease or condition	Hery Discos	e			Onset and Death			
	Medical Examiner		Due to (or as a consequence of):				,	2			
		r	Sequentially list conditions, b. Hypertensia	7			- 1'	1994 Yrs.			
	ured T	Examiner	cause. Enter Underlying Cause (Disease or iinjury								
	an and	Ĕ	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
00	ate be executed physician and the burial transit	dical	d								
687	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	IF FEMALE:								
Box (ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date Mon	of deliver	/ lay Year			
m	he de	ysi	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown	Other (specify)							
P.O.	that the ned by deta	Ş P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	acco use contrib	bute to the	cause of death?			
ds,	quires en sign uld be	ed k	Dementia, Kenal Insuffic	iency,	1 🗆 Yes	2 No :	3 🗌 Proba	bly 4 🗌 Unknown			
Ö	aw rec as bee 2 sho	plet	Part II. Other significant conditions contributing to death but not resulting in the a Dementia, Renal Insuffic Abdominal Abdo	15 m	24a. Was an autopsy		ere autops	y findings available pletion of cause of			
Re	sician: The law certificate has b irector, page 2 s	Completed by			perform 1 Yes 2	ed? de	eath?				
ta	cian: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check	k only one)						
<u></u>	Physi this c	٠. 1	1		ome 5 Residen						
n 0	ding th. After funer	cate	1 Natural 5 Pending (Month, Day, Year) injury	28c. Injury at work? M 1 \sum Yes 2 \sum No	28d. Describe how	injury occurred	d				
<u>S</u>	Atten r dea ctor: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Stre	et and Number	or Rural R	oute Number,			
Division of Vital Records,	s afte		building, etc. (Specify)		City or Town,	State)					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inves	occured at the time, date and place, an	d due to the cause	e(s) and manner	r as stated.	e(s) and manner stated			
	the I	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	20		29b. Signature and title of certifier (over; ng MD Physician	29c. License number	29	d. Date signed	(Month, Da	y, rear)			
			30. Name and address of person with completed cause of death (Item 23a) (Type F	Print) 7500 6-00 11	VAY C	tr. D.	. #	430			
			30. Name and address of person with completed cause of death (Item 23a) (Type, F Stuart Turkewitz, MD	Greenbelt	MD 2	0770	. ,— 3				
	Stat		31. Date filed (Month, Day, Year) 32 Registrar's Signature	whol		•					
	Registra	ar	JUL 05 2012 Samue B. 19	-							

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Dhusisia		I- For State Registrar 1. Decedent's Name (First, Middle,L	ast)	Cei	rtificate	of Deal	th		2. Date of De	Reg. No.	0 1	3. Time of Death
Physicia Medical Examir	er	James Flem:	ing Jr.						Month July 3, 20	Day Ye		1625 hrs
		4a. Facility Name (if not institution, 801 Winters Lane Apt. 2				1	Town, or Loca nsville	tion of Deat	1	4c. County Baltimo		
Funeral Director		231 54 3562 1	Sex 7. Ag		ast birthda	y) If Und Monti		Under 24Hr: Hours Mir	_	13 1941	Foreig	
leath with the Maryland ritems 23a or 28a-f show any tust he notified at once.	-	Usual Residence of Decedent 10a. State 10b. County MD Baltime 10e. Street and Number	ore		Town or L	ville 10f.Zip				10g. Citizen of W	hat Cou	10d Inside City Limits 1 XYes 2 No
ith the M		801 Winters 1	Lane	Ever in U	S. 13		1228	Origin? (S	US Specify Yes or No- 14. Race - Arr			ican Indian, Black,
2 5 5	Fune	1 Never Married 2 Married 3 Widowed 4 Divorce	ied Armed Forces' 1 Yes 2 ced If Yes, Give Yeer or Dates:	X No	1	If Yes, spec	ify Cuban, Me	cican, Puerto ecify:	Rican, etc.)	Whit Specify:	White, etc. Black Specify: 16b. Kind of Business/Industry	
036 ithin 72 hours ne. r than "natu	Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12) 1 2	College (1-4 or		duri	ng most of wo	Occupation (Grking life, DO nstall	NOT use ref	ired)	Priv	Private	
MD 21215-0036 d 2 should be filed within 72 hou lth and Mental Hygiene. n 27 is marked other than "ma numatic event, the Medical Ex	To Be Cor	17. Father's Name (First, Middle, La James Flemin 19a. Informant's Name/Relationship	g	18.Mother's Name Luellen int) 19b. Mailing Address (Street and Number or F			n Silv	er		Zin Code)		
and 2 shou lealth and M	L	Joyce Flemin		206	110	060 W∈		h Ct			, N	ID 20603
Baltimore, N permit. Pages I and Department of Health Important: If item		1 Burial 2 X Cremation 4 Donation 5 Other Spec	cify:	ate Ch	crematory 1esar	or other place beake)	7/1	1/2012	Belts	svil	le,MD neral Home
Ball permit Depar Impo		21. Signature of Funeral Service Like	tax	_	2	2294 (old Wa	shin	gton R	d.Waldo	orf.	MD 20601
Physician Wedical Examiner										Approximate Interval Between Onset and Death		
od ssit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							10		
		UNPENDED	dAMENDED									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of past 12 months? 1								23d. Date o Month		y Day Year	
ires that the signed by the	<u>a</u>	Part II. Other significant condition Diabetes Mellitus	ns contributing to deat	h but not r	esulting in	the underlying	g cause given	in Part I.	1 Y	es 2 No 3	_	the cause of death?
of Vital Records, P.O. by Physician: The law requires that the three this certificate has been signed by meral director, page 2 should be detach	Completed				-				1 Yes	opsy ormed?		topsy findings available completion of cause of
Vital ysician: his certif	8	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpa		26.Place of D			Residence 6	✓ Othe	r: Scene
ion of V tending Phy eath. tor: After th the funeral d	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin, 2 Accident Investig	28a. Date of Inju	ID/	<u> </u>	e of Injury D:	28c. Injury at		28d. Describe	how injury occur posed to hot	red	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical Certification:	3 Suicide 6 Could r	28e. Place of Ir		ome, farm,		y, office buildir	ng, etc.	or Town,			ral Route Number, City sville, MD
To the Hospita within 24 hours To the Funeral completely fille	dical		sician: To the best of miner: On the basis of exa									
\$ 1 × 1 × 1	Me	29b. Signature and title of certifier	and manner stated.			29	c. License nur			29d. Date sign	'	nth, Day, Year)
01-5		30. Name and address of person w	ho completed cause of							July 4, 20		
Str	ate		Medical Examine					re, MD 2	1223			
Regist	rar	31. Date filed (Month, Day, Yet) 6	2012 Dene	سا	p. 1	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUIV 11 Day 2012ª 7:20P. Feldman Joseph George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Prince George's **Examiner** Bowie Golden Age at Avalon Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 🗆 F Months Days Min. 074-12-1714 90 Juliv27*,1921 Bronx, NY **Director** Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must be Funeral 20715 12200 Malta Lane United States if and 2 should be filed within 72 hours after death volf Health and Mental Hygiene. If them 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes ŽXX No Specify Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accountant/Auditor accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sadie Shafer Feldman Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12200 Malta Lane Bowie, Maryland 20715 Shirley Feldman -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date Page 1 crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cenetery: 7/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Licenses Borrald Aves Borrald Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Physician/ Normal Pressure Hydroce halus disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Examir Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performe 2 X No ☐ Yes Yes Be Was case referred to medical 26. Place of Death (Check only one) examiner? ž X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Assisted Lvg 28a. Date of injury (Month, Day, Year) Certificate: Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 12, 2012 059633 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenn Jacob, M.D. KP Largo Medical Ctr. 1221 Mercantile Lane Largo, Maryland 20774

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

Tarks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Mildred V. Gorham June 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a St Agnes Hospital Balfimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Days 579-18-8123 89 Director 1 M 2 X 1922 Virginia Dec. 26, 10c. City. Town or Location 28a-f shov 10b County items 23a or 28a-1 suc iner must be notified at Director 1 Yes 2 X No Catonsville MD Baltimore . Page 1 and 2 should be filed within 72 hours after death with the I ment of Health and Mental Hyglene. Each! If then 27 is marked other than "natural", or items 23a or 2 tant! If then 27 is marked other than "natural", or items 25a or 2 lant into other traumatic event, the Medical Examiner must be no 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral USA 21228 715 Maiden Choice Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3x Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Dept. Agriculture Procurement Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna Drexler Clarence Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Crofton, MD 1861 Kings Place, Michael A. Gorham / Son Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Davidsonville, MD Lakemont Memorial Gar 7/6/2012 4 Donation 5 Other (Specify) 21. Signat Junera Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disease, o complications that caused shock, or heart failure list only one cause on each line. Interval Between Onset and Death End Stage Physician/ disease or condition Medical resulting in death) Due to (or as a consess ence of) Examiner neumonia Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Cause (Disease or Injury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 し
D
X
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D IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 M signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Fibrillation, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy this certificate has RHAM 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After Natural injury work? 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anil Nadifelli 900 S. Ca to: S. Caton Avenue, Baltimore

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

05 2012

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 For AMEND#2 per PHY State AMEND#10e Per FH 7/5/2012 Registrar AACO HEALTH DEPT (MH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6/29/2012 3. Time of Death Physician/ 7:00 PM LUCILLE T. GHIARDI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CROFTON CARE AND REHABILITATION CENTER CROFTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 367-18-5127 1 □ M 2 🎇 F MICHIGAN 9/29/1921 90 Usual Residence of Deced ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified et 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🌠 No CROFTON MARYLAND ANNE ARUNDEL 10e. Street and Number Chaptian 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21114 2803 CHAPMAND COURT 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married within 72 hours after Ś Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 x Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ JOHANA TORREANO JOHN TORREANO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2803 CHAPMAN COURT, CROFTON, MD 21114 GIANCARLO GHIARDI/SON Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any Injury or of once. HESAPEAKE CREMATION ENTER 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/3/2012 STEVENSVILLE, MD 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE 814 BESTGATE ROAD ANNAPOLIS, MD 21401 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Condio Vascular Distase J-type-tensive
Dueto (or as a consequence of): disease or condition rear Medical resulting in death) Examiner Sequentially list conditions, Examine sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit that the death certificate be executed Dementio Due to (or as a consequence of): Physician/Medical ZUNE Box 68760 the IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day g Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier anola D20108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARORAMD. 14300 GALLANT FOXLN#222 BOWIE RAKESH 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26/2012 Bertha Arelene Griffin 8:15a M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hearltland Nursing Home Adelphi If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9/24/1937 **Director** 579-82-3495 1 🗆 M 2 🔀 F 74 North Carolina Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a arminury or other traumatic event, the Modifical Concession of the Conces 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Adelphi MD Prince Georges 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 1801 Metzerott Road 20783 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ If Yes, Give Year or Dates Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Alexander Parker Hattie Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 816 Decatur St., NW Washington, DC 20011 Bessie Adams - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 7/2/12 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake 22. Name and Address of Facility W.H. Bacon Funeral Home 21. Signature of Funeral Service Licensee Jacon CC0361 3447 anda C 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ eroscierosc disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cue to for as a nonsequence ofly cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and prompletely filled in by the funeral director, page 2 should be detached for use as the burilarizability. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Willersitu

MD

Tahmine Ahmed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0060100

Blud East, Silver Spring MD 20903

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		tificate of L			leg. No. 201	2 23 127	
Ħ	Physicia		1. Decedent's Name (First, Middle, Last)	is Lamb	Gras	smuck		2. Date of Deat Junte	th 29 ^{Day} 2012 ^{Year}	3. Time of Death 9:37p _M	
_)	Medic Examin		4a. Facility Name (if not institution, give si Maple Ridge As	reet and number) sisted Livi	ng	4b. City, Town, or Rocky	Location of Death		4c. County of Dear Montgo		
Ī	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 2 / 2/3h, Pqy,	9. Bir Cal	thplace (State or Foreign unitationnia	
	aryland a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgom	,	Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	with the M. 23a or 28 ust be noti	Funeral Director	10e. Street and Number 15908 Maple Ri	dge Court		10f. Zip Code 208	353		10g. Citizen of What Co	ountry?	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates.		Vas Decedent of H f Yes, specify Cuba	Ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
1215-0	hin 72 hou ne. than "natu se Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give I	lent's Usual Occup kind of work done of O NOT use retired) Associa	during most of work .	ing	16b. Kind of Business Non-pro	1	
Baltimore, Maryland 21215-0036	be filed wit ental Hygie ked other ic event, th	To Be C	17. Father's Name (First, Middle, Last) W. Ray Lamb	J+			18. Mother's Nam	e (First, Middle, I dys Ja:	Maiden Surname) Mes		
Mary	d 2 should alth and Ma 27 is mar or traumati		19a. Informant's Name/Relationship (Type Karen Kraushaar	_		-			City or Town, State, Zi		
imore,	Page 1 and nent of Hermant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	20c. Location - City of Beltsvil	le,Md						
Balti	permit. Departr Imports any inji		21. Signatur of Foneral Service Lice is	mull		Namelar Addre	sRFNALDI umbia Bl	FUNER vd.Sil	AL SERVIC ver Sprir	E,P.A. ng,Md20910	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Immediate Cause (Final disease or condition Failure to thrive										Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		ia			years	
	outed nd and Cansit	kamine	Sequentially list conditions, if a y lead y conditions, if a y lead y conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to or as a consequence.							
09	cate be executed physician and sthe buriatransi	edical Examiner	resulting in death) Last Due to (or as a consequence of): d								
	ath certifi attending for use a	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 \$\frac{1}{2}\$No g Unknown	23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of o	ldeath 3	Ectopic pregnan Other (specify)	су		23d. Date of do Month	elivery Day Year	
s, P.O.	requires that the dear been signed by the a should be detached	d by Ph	Part II. Other significant conditions co		ulting in the u	underlying cause g	iven in Part I.		obacco use contribute t	o the cause of death? Probably 4凶 Unknown	
Record	rsician: The law requis certificate has beer lirector, page 2 shou	Completed by						24a. Was a autop perfor	rmed? prior to death?	utopsy findings available completion of cause of es 2 No	
/ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatie	26. F	Place of Death (Checher:		lence 6 Other (Spe	_{cify)} assisted	
on of V	nding Physath. :: After this e funeral di	icate: To	27. Manner of Death 1 ♣Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time o injury	f 28c. Inju wor	ry at		ow injury occurred	living	
Divisio	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,	
	To the Hospital within 24 hours a To the Funeral E Ompleted filled	Medical	(Check 2 Medical Examin	ician: To the best of my knowl ner: On the basis of examination e Practioner: To the best of my	n and/or inves	stigation, in my opin	ion, death occurred	at the time, date a	nd place, and due to the	cause(s) and manner stated.	
	or this is the state of the sta	2	29b. Signature and title of certifier	a.		29c. Licens			29d. Date signed (Mon July 2	th, Day, Year)	
			30. Name and address of person who con Syresh K. Gupta	ompleted cause of death (Item	1 23a) (Type, Geo:	Print) rgia Av	e. #220	Silver	Spring,	1d 20902	
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Signar	tyre do	whole,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Katherine 7001 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER **OUEEN** 1612 HOWARD ROAD ANNE'S If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** Months Director 1 □ M 2 🕱 F 218-52-6452 Yrs 63 WASHINGTON, DC 08/16/1948 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Manyland must be notified at Director 1 🗌 Yes 2 💢 No MD QUEEN ANNE'S CHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral "natural", or items 23a 1612 HOWARD ROAD 21619 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Yes. Give Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) OFFICE MANAGER HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ARTHUR D. HEATH, SR MARY E. WALLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD R. HOFFMAN / HUSBAND 1612 HOWARD ROAD, CHESTER, MD 21619 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place LAKEMONT MEMORIAL GARDENS 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/06/2012 DAVIDSONVILLE,_MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Vagan disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialby Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1-Natural 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 L 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hee 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registr<u>ar</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Boyd June 3:00 Catherine Hugh 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 372 Russell Avenue Montgomery Gaithersburg Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days **Director** 1 - M 2 X F 192-32-0064 Feb. 9, 1914 Pennsylvania 98 Usual Residence of Dec or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be r Funeral within 72 hours after death with United States 20877 372 Russell Avenue items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No
If Yes, Give
Year or Dates. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 K Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the Department of Defense Computer Systems Analyst Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Mary Weigel William Boyd Department of Health and Important: If item 27 is many injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PA. 18020 Noralee Manzek/Niece 3176 Margate Road, Bethlehem, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) July 3,2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Years Metastatic Rectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Pregnant at time of death Month Day Year be detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate by 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 🗌 Nursing Home 5 🔀 Residence 6 🗍 Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year,

State Registrar 31. Date filed (Mor

DHMH 17 Rev 06-2011

Dennis M. Hannon, M.D., 3300 Olney-Sandy Spring Rd., # 330, Olney, Maryland 20832

D 23124

July 2, 2012

mommon amm

Day, Year)

05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month, HOLDBROOKS BEATRICE 11:25 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Hours 109-24-0558 Director 1 - M 2 -Virginia 03 05 1917 ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges 1 X Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12922 Vicar Woods Lane 20720 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify If Yes. Give Completed 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12years Hair Dresser Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည å Randolph Cooper Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Redd/Daughter 12922 Vicar Woods Lane Bowie MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s
Department of H
Important: if its
any injury or ot 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 4 Donation 5 Other (Specify) 7-7-2012 Bronx, New York 21. Suprifure Funeral Service License 22. Name and Address of Facility John T. Rhines Funeral Home M01592 3005 12th Street NE Washington DC 20017 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner NSTEMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burlal-transit ADVANCED ALZHEIMENS Disens Due to (or as a consequence of): resufting in death) Last Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached f 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 XN Yes director. 25. Was case referred to medica Be 26. Place of Death (Check only one) မ 1 ☐ Yes 2 🛣 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ATTENDING 29d. Date signed (Month, Day, Year) PHYSICIAN, MD 06 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar TARAIL

31. Date filed (Month, Day, Year)

12-79

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32 Registrar's Signature

Hospital Drive

Gle- Braic my

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death George Hayes Physician/ ^{Day}2012^{Year} Month 6 1956 26 Medical Facility Name (if not institution, give street and number)
Holy Cross Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver SPring Montgomery **Funeral** 257-62-8207 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours **Director** 1**X** M 2 □ F 72 5/1/1940 Georgia 28a-f shov items 23a or 28a-f shoner must be notified at 10b. County State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Prince Georges Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3559 55th Ave. Apt#4 20784 USA and 2 should be filed within 72 hours after death well health and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. er than "natural", or ite the Medical Examiner 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 XWidowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unknown Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newton Hayes 2 Rena Reese 19a. Informant's Name/Relationship (Type, Print)
Cary Russell/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4444 Swindon Terr. Upper Marlboro, MD.20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Vass, NC 7/7/12 Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fryes Chapel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NE Washington DC 20019 Dunn & Sons-5635 Eads St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) **Examiner** 16h 4 Sequentially list conditions, Examine if any, leading to immediate Due to (or sequence of) cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an Hospital or Attending Physician: The law has page 2 certificate 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 1 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death

To the Funeral Director: A

completely filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis Freisinger-1500 Forest Glen Road

Registrar

State

32. Registrar's Signature

Silver Spring, MD. 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month J111 V Physician/ 2012 9:15 P^{M} MILDRED HARRIS IDA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Jarrettsville Harford 3602 Harris Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 8 g. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕅 F Months Davs Hours Min. Country) Maryland 86 216-20-4542 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Examiner must be notified at Director 1 Yes 2 No MD. Jarrettsville Harford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ò Funeral items 23a 3602 Harris Lane 21084 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other trainmant. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Housewife Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Louis E. Gill Edna Pitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17268 Old Route 16 Street Waynesboro, Gigger (Daughter) Mancy 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of July Date 14 cemetery, crematory or other placel 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) arrettsville Jarrettsville, MD. Cem. 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Home. P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a c sequence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 m onths?
1 ☐ Yes 2 ☑ No Pregnant at time of death Other (specify) the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy death? Yes 2 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 1 No 1 Tes 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No injury 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month. 29b. Signature and titl

State Registrar on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9.14AM 2012 John Medical 4a. Facility Name (if not institution, 4b. City, Toy County of Death **Examiner** 110 11010 If Under 24 Hrs. 9. Birthplace (State or Foreign Age 8. Date of Birth **Funeral** New Jersey Months Hours Min Nov. 28, 1952 216-56-1399 59 1 🖾 M 2 🗆 F Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Prince George's 1 Yes 2 No Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a Funeral 12222 James Madison Lane 20769 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life, DO NOT use retired) College (1-4 or 5+) 1-4 Elementary/Secondary (0-12) self employed Bricklayer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Hubbard Adeline Mary Attilio permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12222 James Madison Lane Glenn Dale, Maryland 20769 Karen Lorraine Hubbard -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/6/2012 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ DTIS disease or condition resulting in death) hours Medical Due to (or as a consequence of **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Linknown Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? certificate has page 2 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient this 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer work? 1 Natural injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MA son who completed cause of death (Item 23a) (Type, Print) 00

DHMH 17 Rev 06-2011

State Registrar Elizabeth Anne Jordan Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend # State of Maryland / Department of Health and Mental Hygiene Unk Unk Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day Year Month D July 8, 2012 1021 hrs **Medical Examiner** Jordan Elizabeth Anne 4a. Eacility Name (if not institution, give street and number)
3420 Newport Avenue 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6 Sex Social Security Number **Funeral** Months Days Hours Mir Dec 14 1957 Mew Jersey Director 54 Yrs 1 M 2 X F 164-38-3390 Usual Residence of Decedent 10d, Inside City Limits 10h County 10c, City, Town or Location 10a State 1 Yes 2 No Annapolis Maryland Anne Arundel 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number USA 21403 3420 Newport Avenue 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes White Specify: Widowed 1 Yes 2 X No specify: 4 X Divorced If Yes. Give Year 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) pleted Anne Arundel Co. College (1-4 or 5+) Elementary/Secondary (0-12) Board of Education Guidance Counselor Baltimore, MD 21215-0036 6yrs 12th Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Moore Be Jerry N. Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33 Sawmill Lane Greenwich, Ct. 06830 Douglas K. Jordan (Brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7-13-12 Baltimore, Md. Metro Crematory 4 Donation 5 Other Specify. 22 Whame and Wesself & Facility Sons Mortuary, 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death Medical a Thermal burns and inhalation of smoke and soot Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit law requires that the death certificate be executed -f.per.me.g929 7-31-12 sm Physician/Medical AMENDED 23a, 27, 28a #4a, per me, 8929 X UNPENDED ned by the attending physician a detached for use as the burial -Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. rcate has been signed by t page 2 should be detache 1 Yes 2 No 3 Probably 4 V Unknown Š Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate has performed? 2 No ✓ Yes 2 No ✓ Yes To the Hospital or Attending Physician: The 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27 Manner of Death subject in house fire Certification 1 Natural 1 Yes 2 X No Division Pending within 24 hours after death.

To the Funeral Director: Director: fd10:21 am fd 7-8-12 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3420 Newport Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide determined (Specify) nnapolis, MD. Found:Residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 9, 2012 O.C.M.E. 0. Name and address of person who completed cause of death (frem 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Russell Alexander MD. 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28 Physician/ 2012 2:50p June Margaret Emily Newton Jones Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Frederick 5726 Jefferson Blvd. 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) eb. 16, Days Vermont 1 □ M 2 🖾 F Months Hours Min. Feb. 1950 Yrs. 013-42-3946 62 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò "natural", or items 23a or Funeral 21703 United States 5726 Jefferson Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 🛚 No 1 Never Married 2 Married 1 Yes If Yes, Give ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Education Instructor event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Emily Chapman Laurence Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 62 Ellis Road, Sullivan , NH 03445 Alan C. Jones Sr. / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Frederick, Maryland. Stauffer Crematory Inc.7/1/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown 21. Signature of Funeral Service Homes Pradick, Maryland 21702 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one gause on each lin Immediate Cause (Final Physician/ disease or condition Medical resulting in death) months metastatic **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence bi). attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No signed by the atte Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?. Yes 2 No 1 Yes 2 No 1 Yes this certificate or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 Natural 2 Accident work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Sician 29,2012 D53590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

SYDKEM

31. Date filed (Month)

PY MO

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634 W

609

Registrar's Signature

EBELLIA

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BROADWAY

21090

MO

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Department State of Maryland / Department State	artment of Health and N rtificate of Death	Mental Hygiene
			Decedent's Name (First, Middle, Last)	in out of a sum	2. Date of Death 3. Time of Death
	Physicia Medic	al .	Lovie Evelyn Kidwell		July 2 2012 1:25 A M
	Examin	er	4a. Facility Name (if not institution, give street and number) Wilson Heath Care Center	4b. City, Town, or Location of Death Gaithersburg	4c. County of Death Montgomery
no de	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign
	Director		577 – 09 – 1115 1 □ M 2 🗓 F 103 Yrs.	Months Days Hours Min.	Nov. 11,1908 Virginia
	how at	. 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
	arylar 3a-f sl iffied a	ecto	MD Montgomery G	Saithersburg	1 🏝 Yes 2 □ No
	the N a or 28		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ns 23. must	Funeral Director	32 Windbrooke Circle	20879	United States
·0	or iter	by Fu	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	scify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
933	urs afte ural", I Exar	ted b	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🙀 No Specify:	Specify: White
15-	/2 hou	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing 16b. Kind of Business Industry Company
212	vithin giene. er thai			nistrative Supervi	
Maryland 21215-0036	oud be filed within 72 hours after death with the Maryland def Mental Hygiene. Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "dedical Examiner must be notified at matic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) William Bush	1	e (First, Middle, Maiden Surname) inia Westcott
ary	permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Maili	ng Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)
Σ.	nd 2 sl lealth a m 27 i ner tra		Yaughin 10000 (Company)		Gaithersburg, MD 20879
Baltimore,	ge 1 a nt of H : If ite		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition 20cernetery, cre	matory or other place) • T 1.	Date 20c. Location - City or Town, State
	nit. Pa artme ortani injury		24 Cimpature of Euperal Contina Licenses	2 Name and Address of Facility	012 Alexandria, VA
ñ	Dep Imp any	0 1	TRACA A TUNER MO1117 DO	eVol Funeral Home, Gaithe	10 East Deer Park Drive, ersburg, MD 20877
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between Geset and Death
Þ	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (As a consequence of):	nearl factor	20 Sonset and Death
-	Examiner		arteriorde	Reartfaile	oncular
	± 1	Examiner	cause. Enter Underlying		siace
	be executed sician and purial transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last		
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6876	ing phy	/Mec	IF FEMALE:		
Box 6	arn ce attend for use	cian/	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23d, Date of delivery Month Day Year
M ·	the de by the ached	Physician/Med	1 Yes 2 No 9 Unknown		
P.O.	requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
rds	require seen s should	Completed by	Octoment + Harather id	Western	24a Was an 1/24b. Were autopsy findings available
ecc	sician: The law is certificate has the lirector, page 2 s	duo	of cerebrouse ula suid	e et	autopsy performed? prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
a H	rnysician: The lar r this certificate ha rral director, page 2	Be C	25. s case referred to medical examiner?	26. Place of Death (Chec	
Z Z	rnysic this ce ral direc	욘	1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatie		ome 5 Residence 6 Other (Specify)
ם '	ding F h. After 1 funer?	cate:	27. Manny r of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
Division of Vital Records,	l or Attendi after death. Director: A I in by the fu	Certificate;	3 ☐ Sulicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
ā ;	pital o ours af eral Di filled ir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place at	nd due to the cause(s) and manner as stated.
:	Io the Hospital or Attending Prystolan: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phystompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check (Check only one) 3 ☐ Certifying Physician: To the best of my knowledge, death (Check only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	it the time, date and place, and due to the cause(s) and manner stated.
_		_	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			J. Schutterselbarana	04/15	any a 2012
			30. Name and address of person who completed cause of death (them 23a) (Type, V < Robert T BIRSCHBACH, MA	J. Carthers	burg wel 2084)
	Sta Registr		31. Date filed (Month, Day, Year) 31. Registrar's Signature	whol	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2012 6:15 A M Susan Elizabeth Kornacki Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick **Knoxville** 19108 Sandy Hook Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🔀 F Hours $Ju_{1}^{(Month, Day, Year)}$ 48 63 MD Director 217-56-1597 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Knoxville Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19108 Sandyhook Rd. 217<u>58</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes 2 🖾 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Aide medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Louis Miller Margaret Elizabeth Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19108 Sandyhook Rd., Knoxville, MD 21758 Edward Kornacki/husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Stauffer Crematory 07/10/2012 4 Donation 5 Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_j i ian/ second Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) weeks attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear Pregnant at time of death Other (specify) 9 Unknown been signed by the s should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 X No 1 Yes 2 No certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director, Be 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02 2012 Oh, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \ \ Yun \ \ Whan 21702 46 Drive chusen homes 31. Date filed (Month, Day 5 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MARKETA.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ OWE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Season's Hospice Social Security Number 7. Age (In yrs. last birthday) Funeral 45 **Director** 218-78-6033 1 🗆 M 2 🗓 F Vrs or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director MD Baltimore **Baltimore** 10e. Street and Number Hygiene. other than "natural", or items 23a Funeral 8026 Bank St. 11. Marital Status 12 Was Decedent Ever in U.S. Was Deceuen, ____ Armed Forces? 1 ☐ Yes 2★ No 1 Never Married 2 Married ğ Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Be Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 2 James Thomas permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) Eva Marie Milburne / Daughter 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Part 1. Enter the dig shock, or heart fallu Immediate Cause Unal disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown been signed be should be deta <u>۾</u> Records, Completed page 2 s this certificate has within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be examiner? 2 No ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be determined Medical 29a. Certifier

4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Davs Hours (Month, Day, Year, Mar. 9, 1967 Marvland 10d. Inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? USA 21224 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No Specify: Specify. White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Annette Oberholzter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8026 Bank St., Baltimore, MD 21224 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory 6/30/2012 Baltimore, MD Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest filtre. Pist only one cause on each line. Approximate Interval Between Dnset and Death 23d Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Dutpatient 3 DOA 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Narpe and address of person who completed 31. Date filed (Month, Day, DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2. Date of Death

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Ot-t-	epartment of Health and N Certificate of Death	, ,	ene g. No.
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Joseph Thomas Lawrence		2. Date of Death Month July	3 Day 2012 Poar 23. Time of Death 3
	Examin		4a. Facility Name (if not institution, give street and number) Hospice of St. Marys	4b. City, Town, or Location of Death Callaway		4c. County of Death St. Mary's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe 216 28 8426 1X M 2 G F 81 Y	day) If Under 1 Year I f Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar 21	Birthplace (State or Foreign
	/land f show ed at	tor	Usual Residence of Decedent			10d. Inside City Limits
	ne Mary or 28a- notifie	Director	MD St. Mary's Valle	10f. Zip Code	100	g. Citizen of What Country?
	s 23a o	Funeral	44964 Hewitt Road	20692	100	US
900	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Was Decedent Ever in U.S. Armed Forces? 1 ☐ Was Decedent Ever in U.S. Armed Forces? 1 ☐ Was Decedent Ever in U.S. Armed Forces? 1 ☐ Was Decedent Ever in U.S. Armed Forces?	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	in 72 hou e. nan "natu Medica	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	ing 16	6b. Kind of Business Industry
27	dygien Hygien Ither th	Be Co	10th 17. Father's Name (First, Middle, Last)	Transportation		Government
ylan	ild be filed Mental Hy harked oth	10	Walter Lawrence		e (First, Middle, Mai y Mason	iden Surname)
	nd 2 should be i salth and Ments n 27 is marked er traumatic e	- 83		Mailing Address (Street and Number or Rure 080 Mojave Drive		
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		1 ✓ Burial 2 Cremation 3 Removal from State cemetery,	Disposition (Name of crematory or other place) George Cem July		Oc. Location - City or Town, State Valley Lee, MD
Balti	permit. Page 1 Department of Important: If i any injury or c once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility T	scoe-To	onic Funeral Home Waldorf,MD 20601
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each and	/- //		Interval Between
	Physician Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of	tre Cancer		Onset and Death
ı	Examiner	ner	Sequentially list conditions, if any leading to immediate Due to for as a consequence of			
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of	:		
200	icate be executed I physician and s the burial-transii	Nedical	d			
. Box 68	death certific he attending ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O	The law requires that the ate has been signed by to page 2 should be detach	ted by Pl	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Reco	The law ate has page 2	Completed			24a. Was an autopsy performe	24b. Were autopsy firmlings available prior to completion of cause of death? No 1 Yes 2 No
ıtal	ysician: The lar is certificate ha director, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check		105000
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate: To	27. Manner of Dea h 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Tir injury		me 5 ∐ Residenc 28d. Describe how	te 6X1 Other (Specify) H() Spick injury occurred High School Scho
DIVIS	tal or Att		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	he Hospit in 24 hour ne Funera pleted fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	investigation, in my opinion, death occurred at	the time, date and p	place, and due to the cause(s) and manner stated.
_	To the with com		29b. Signature and title of certifier	29c. License number	751 290	1. Date signed (Month, Day, Year)
	00/41		30. Name and address of person who completed cause of death (Item 23a) (Ty	(pe, Print)	# 2001-	07-03-2012 Nardtum, Ma 20650
	Stat Registra		31. Date filed (Month, Day, Year) JUL 0 6 2012 32. Fegistrar's Signature	bars	as Leo	Marcau Mi 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Carolyn V. Lockard 2. Date of Death 3. Time of Death Physician/ Take 20192 Z83 4AM Medical 4a. Facility Name (If not institution, give street and number)
Doctors Community Hospital 4b. City, Town, or Location of Death Examiner Lanham P.G. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 578-60-0810 Hours Min **Director** 1 □ M 2 1 F 65 Feb.8,1947 Washington, DC 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at **Funeral Director** Md. P.G. Greenbelt 1 🔀 Yes 2 🗌 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 7305 Morrison Drive 20770-2447 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 X Married 2 X No ☐ Yes Yes, Give Black 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working than Elementary/Secondary (0-12) College (1-4 or 5+) Optical Technician Optical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ဂ္ James Lester Jones Florine Estelle Robinson Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Wilbur Lockard-Husband 7305 Morrison Drive Greenbelt, Md. 20770-2447 Health atem 27 i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Dat 2012 20c. Location - City or Town, State Department of I Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial July10, Suitland,Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 20001
Robinson Funeral Home 13136thSt.NWWashDC f Funeral Service Licensee 23a. Part I Inter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Ph_sician/ Myo cardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of congestive that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has autopsy performed? 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 Yes 2 No 5 Pending ours after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 07/02/2012 respe vonic 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 breen belt Road Suite Lanham 2070 #101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year July 9 3:43P. Linda Marie Langs Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casev House Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Month, Day, Year, 1953 Hours Min 243-94-7878 Washington, DC 1 DM 2 AF Director 58 Usual Residence of Decedent Hygiene. other then "neturel", or items 23e or 28e-f show vent, the Wedleal Exeminer must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖹 No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 United States 18815 Clover Hill Lane 12. Was Decedent Ever in U.S. Armed Forces 7

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filer of Health and Mental H I item 27 is marked ot ၉ Doris Gill George B. Rouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip. Code) 18815 Clover Hill Lane Olney, Maryland 20832 Steven E. Langs -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery 7/13/2012 20c. Location - City or Town, State permit. Page 1 and Department of Hamportent: If ite eny injury or ot 1 Durial 2 Cremation 3 Removal from State Adelphi, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bonald Vires Borg Wardt Funeral Home, Worald UBor 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or com. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Renal Cell Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien end for use es the burial-transit death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day Year ed by the e Hospital or Attending Physicien: The law requires thet the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has t કો director, page 2 કા autopsy this certificate 1 Tyes 2 XNo 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) 1 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No in 24 hours after death,
he Funeral Director: After this c
pletely filled in by the funerel dir ဂ္ hospice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mapper of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60634 July 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

P.O. Box 68760

Records.

32. Registry 's Signature

Bindu C. Joseph, M.D. CH 6001 Muncaster Mill Road Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 28 2012 1:22p J<u>une</u> Gerald L. Miss Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Carroll 5710 Cabbage Spring Road Mt. Airy 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth
(Month, Day, Year)
Sept. 30,1950 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 1 🛛 M 2 🗆 F Months Sept. Director 218-50-4220 61 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò ral", or items 23a or Examiner must be with 1 Funeral 21701 157 West All Saints Street United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 🔀 No If Yes, Give and Mental Hygiene.
is marked other than "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Artist Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Anna Pazdersky permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Robert E. Miss Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Lockard/ Friend 5710 Cabbage Springs Road, Mt. Airy, MD 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 D Cremation 3 Removal from State Stauffer Crematory Inc.7/2/2012 4 Donation 5 Other (Specify) Frederick, Maryland. 22. Name and Address of Facility.
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signatur Funeral Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pnysician/ Metastatic arroy CONCET Dharynx disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Directo (or as a convergrence of) and transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e Hospital or Attending Physician: The law 124 hours after death.

• Funeral Director: After this certificate has leted filled in by the funeral director, page 2.9 autopsy performed! 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{Z}\) Residence 6 \(\sum \) Other (Specify) 2 X No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 採 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD N35051 00 29 2012 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koch MD 601 North Caroline Street, Baltimore, Maryland Wayne M. 31. Date filed (Month, Day, Year) Registrar's Signature State 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ LaFrances Taylor McIver June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5816 Jefferson Heights Drive Capitol Heights Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 579-30-0257 **Director** 1 □ M 2**X**□ F 05/22/1928 Wash.,D.C. Usual Residence of Decedent show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State the Maryland notified at Director Md. Capitol Heights P.G. 28a-f 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ms 23a or r must be r Funeral 20743 5816 Jefferson Heights Drive U.S.A. ed other than "natural", or items event, the Medical Examiner mu and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black "natural", Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) 12th College (1-4 or 5+) Accountant-U.S.Marine Corps U.S. Government and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Walter Kelly Taylor Mary Jane Boddie or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Freda R. Reynolds/Niece 1508 Beaver Heights Lane, Capitol Heights, Md. 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot . Page 1 1X Burial 2 Cremation 3 Removal from State 07/06/12 4 Donation 5 Other (Specify) Harmony Mem. Park Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. rall CC0316 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam 9 ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 063748 July 3,2012 Jocelyne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Jocelyne Kouatchou, M.D.

32. Registrar's Signatu

4041 Powder Mill Road, Beltsville, Maryland 20705

nck Indelible Ink. Ensure All Copies Are Legible. Department of Health and Mental Hygiene

12-03273	Please Type or Print in Black
Ferdinand Muffoletto	State of Maryland / De

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		1- For State Registrar	Certificate of Death					012 2014	
Physician/		Decedent's Name (First, Middle,Last)					Date of Death Month Day Year		
Medical Exami	ner	Ferdinand Michael	Muffe	oletto		July 13, 20	012	1038 hrs	
		4a. Facility Name (if not institution, give street and number) 9009 Briar Road	4b. City, Town, or Location of Death Parkville			ath	4c. County of Death Baltimore County		
Funeral		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birt					Birthplace (State or	
Director		213-32-3204 155M 2 F	75	Yrs. Months Day	s Hours N	Min. Aug 22		Foreign Country) MD	
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any		10a. State 10b. County 10	c. City, Town	or Location			•	10d. Inside City Limits	
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0036 within 72 hours after death with the Maryland jone. ner than "natural", nr items 23s or 28s-f sho Mejical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ev	er in U.S.	13. Was Decedent of His	spanic Origin? (- 14. Race -	American Indian, Black,	
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21215-0036 uld be filed within 7 Mental Hygienc, marked nither than c event, the Medica	To Be	Salvatore Muffoletto 19a. Informant's Name/Relationship (Type, Print)	198	Mailing Address (Street		n Galo	ober City of Town	State Zin Code)	
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Baltimore, permit. Pages I an Department of Hee Important: If ite injury or nither tr	ŀ	4 Donation 5 Other Specify: 27. Signature of Funeral Service Licensee	Kride	rs Cemetery	s of Facility • .	/16/2012	Westmin	ster, MD	
Baltimo permit. Page Department c Important: injury or nut	1	e. agriature of Furieral Savice Licensee		410 F71	Prit	tts Funer	al Home	& Chapel, PA	
Physician	\dashv	23a./Part I. Enter the disease, or complications that caused the	e death. Do no	412 Washing					
/Medical		failure. List only one cause on each line. Between Onset and Death							
Examiner		Immediate Cause (Final disease or condition resulting in death) aBleeding Gastric Ulcer Due to (or as a consequence of):							
Sequentially list conditions.									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
ecuted and transit		d,							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Physician/Medical	■ AMENDED AMENDED AMENDED 23a,pt.II,27,per me,g930 8-29-12 sm							
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that the death certined by the attending detached for use as	돌	Part II. Other significant conditions contributing to death be	ut not resulting	o in the underlying cause	given in Part I	23e Did to	phacco use contrib	oute to the cause of death?	
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Rec The l	Completed					1 Yes		Yes 2 No	
Division of Vital Records, rate or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should it	8	25. Was case referred to medical examiner? Hospital: 1 Innatiant 2 EP/Outnatiant 3 DOA Other Nursing Home 5 Positiones 6 Other Second							
F Vi Physic r this	흔	1 ✓ Yes 2 No		utpatient 3 DOA			Residence 6	_	
ding Pl		27. Manner of Death 28a. Date of Injury (Month, Day, Year) Pending) 28b.		ry at Work?	28d, Describe	now injury occurre	a	
ivision or Attene after death Director:	뷿	Pending 1 Yes 2 No Investigation 1 Yes 2 No							
Divis Di	Certification:	Suicide 6 Could not be					Location (Street and Number or Rural Route Number, City or Town, State)		
. <u> </u>	Ö	4 Homicide							
H 7 E 3	Medical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
To the within To the comple	Ned Ped	and manner stated, 29b. Signature and title of certifier		29c, Licens				d (Month, Day, Year)	
		11/1	20	O.C.			July 14, 201		
		30. Name and address of person who completed cause of dear	th (Item 22=)				1,,		
		Russell Alexander MD. Assistant Medical	. ,	900 W. Baltimore	Street. Bal	timore, MD 21	223		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									
State 31. Date filed (Mogth, Day Year) 32. Registrar's Signature Registrar JUL 2 0 2012 Denote A. Sauce									
							OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vid McCumbe		1- For State Registrar	State	e of Maryland	-	rtment of ificate of		l Mental H		Reg. No.	20	12	2311
Physicia dical Exami	an/	1. Decedent's Nam David		Wayne	McC	'umbee			2. Date of De Month June 9, 2	Day	Year	3. Time o	
1		4a. Facility Name (522 Bridge	if not institution, g				b. City, Town, or L Hancock	City, Town, or Location of Death ancock			ounty of Deat ashington		
Funeral Director		5. Social Security N 236–90–66		Sex 7. Age	(In yrs. las 52	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mi		irth(MM/DE 7/1959	9. Bi Forei Co	rthplace (Si Washi ountry)	iate or ington, DC
any		Usual Residence o 10a. State	f Decedent 10b. County		10c. City, T	Town or Location	on					10d. Insid	de City Limits
	5	WV	Morgan		Be	erkeley	Springs					1Y	es XXX No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Nu	mber ewelyn C:	ircle			10f. Zip Code 25411			10g. Citizei	n of What Cou USA	intry?	
Halfimore, MIU 21219-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	ed 2 Marrie	12. Was Decedent Armed Forces?			Decedent of Hisp es, specify Cuban,			0- 14	Race - Amer White, etc.	rican Indian Vhite	n, Black,
ours after atural", caminer	à	3 Widowed 15. Decedent's Ed		ed If Yes, Give Year or Dates: only highest grade com		16a. Decedent	Yes 2 No 's Usual Occupation st of working life.	on (Give kind of		Specify: 16b. Kind of Business/Industry			
U36 ithin 72 han. ne. r than "n fedical E	Completed	Elementary/Second 12	ondary (0-12)	College (1-4 or 5	(+)	_	ll mechai		tiled)	Ca	arpenti	-Y	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Col	17. Father's Name Henry	(First, Middle, Las	Frank	Мс	:Cumbee		8.Mother's Nam Armeta	e (First, Middle, Ma	Maiden Su AC	rname) Whisr	ner	
MID 21213-0036 d 2 should be filed within 72 hours after the and Mental Hygene. n 27 is marked other than "natural", numatic event, the Medical Examiner.	٩		. McCumb			637 Ma	Address (Street awani Vi	llage L	ane, Bei	rkeley	y Sprin	ngs, V	vv 254
Baltimore, MD. Demrit. Pages 1 and 2 sho. Department of Health and 1 important: If item 27 is injury or other traumatic		P-44-4		Removal from Sta	cr.	ematory or oth	tion (Name of cemer place) Cemetery		Date 14/2012		cation - City or celey S		
balti permit Departm Importi injury		21. Signature of Fu	neral Service Lic	ensee	100522	95	nsiey⊸yol Union S	treet.	Berkele	y Spr	inas. V		
Physician Medical Examiner		23a. Part I. Enter the failure. List on Immediate Cause (or condition resulting)	ly one cause on Final disease	pplications that caused each line. a. Multiple Injuries Due to (or as a conse		Do not enter th	e mode of dying, s	such as cardiac	or respiratory a	rest, shock	, or heart	Approxi Betwee	imate Interval en Onset and Death
	ē	Sequentially list co	nditions,	Due to (or as a conse									
cuted and transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):											
e execut cian and rial - tran	dical	UNPENDED		AMENDED									
LIVISION OT VICAL RECORDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours ather death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi	ž	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 23d. Date of delivery Month Day Year											
at the deat d by the at stached for		Part II. Other eigni		9 Unknown contributing to death	but not res	suiting in the ur	nderlying cause gi	ven in Part i.			e contribute to		
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ecords, he law requir ne has been s nge 2 should 1	Completed		•••	<u>.</u>		_		.	auto	psy orm <u>ed</u> ?		completion	of cause of
VITAI KEC hysician: The l r this certificate l al director, page	Be	25. Was case refer examiner?		D 9.5				of Death (Check	only one)				
Physic Physic rer this eral dire	은		2 No	Hospital: 1 Inpatie		R/Outpatient 28b. Time of In			ing Home 5			er: Scene	
SION OF Attending Pl death. xctor: After by the funera	Certification:	1 Natural 2 Accident	5 Pending Investiga	Jun 8, 2012	ear)	1311 hrs	1 Ye	es 2 🗸 No	Driver auto	auto co	llision		Number Oil
DIVISION E Hospital or Attendi 1.24 hours after death. E Funeral Director:	Certifi	3 Suicide 4 Homicide	6 Could no determin	ot be			t, factory, office bu	maing, etc.	28f. Location or Town, 522 Bridge,	State) Hancock,	MD MD	urai Route i	Number, City
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2		clan: To the best of my er: On the basis of exar and manner stated.	_								
2m	Me	29b. Signature and	tirle of certifier	/			29c. License O.C.M				te signed (Mo	onth, Day, Yo	ear)
OCME		30. Name and addr Mary G. Rip		completed cause of deeputy Chief Medic			W. Baltimore	Street, Balti	imore, MD 2	1223			
		31. Date filed (Mon	th, Day, Year)	32. Registrar									
Regist		101 3	0 2012	Denne ,	9. 19	ORIGINAL	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 6:19 A ORLANDO NAVARRO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Oxon Hill 1300 Owens Road Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 1 🗓 M 2 □ F 562-86-4728 Director 68 Feb. 2, 1944 **Philippines** Usual Residence of Decedent or 28a-f show be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a odical Examiner must be Funeral **USA** 20745 1300 Owens Road 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 M Yes 2 No Retired
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 Specify: Filipino 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 1989 Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Military Military US Navy and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. 2 Conte Gregoria Navarro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14435 Golden Oak Court, Centreville, VA 20121 Erlinda C. Navarro/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
MD. Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 7/11/2012 Cheltenham, MD 4 Domation 5 Other (Specify) of Funeral Service Lix ee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745 ala Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Day Month Year Pregnant at time of death g Unknown g Unknown by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital 2 🗌 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 10 Natural 5 Pending nours after death.

neral Director: Aft
filled in by the fur Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined hours after City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Signatu and title of certific and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Manoj S.

31. Date filed (Month, Day, Year,

7801 Old Branch Avenue,

MD

05 201

Reddy,

20735

Clinton, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 MINNA NELSON Physician/ 4:55 A M 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ershill Montgomer eseness 82 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗌 M 2 🏋 F Days Hours Months 1*0*%4%1924° Jamaica 112-34-3568 87 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Olney Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20832 16732 Gooseneck Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospitality <u>Seamstress</u> +h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Morgan Sydney Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16732 Gooseneck Terrrace, Olney, MD 20832 Howard Robinson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1X Burial 2 Cremation 3 Removal from State Gate Of Heaven 7/5/2012 Silver Spring, MD 4 Donation 5 Other (Specify) Snowden Funeral Home 22. Name and Address of Facility Signature of Funeral Service Mois 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, ician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dish to for as a nonsectionne offi been signed by the attending physician and should be detached for use as the burial transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death 1 ☐ Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 perform 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Sompleted filled in by the funeral director, 1 🗆 Yes No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending Natural Accident Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signat and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Item 23a) (Type, Print) Bel Pre Road, Silver Sprin 3227 31. Date filed (Month, Day, Year) Registrar's Signature State 05 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 July Physician/ EDWARD PAUL O DOMMETT SR. :25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford 2144 Schuster Road Jarrettsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Country) ew York 8/29/1 Months Hours Min. 212-18-8168 90 Director Usual Residence of Decedent 28a-f show 10a. State 10b County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Harford Jarrettsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2144 Schuster Road 21084 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 M Married by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed 3 Divorced TT White WW 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Shell Oil Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည O'Donnell Charles Francis Martha Louise Dean 1 and 2 should b of Health and Mer item 27 is mark other traumatio 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. O'Donnel Schuster Rd. Jarrettsville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jul Pate 18. permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State liam Watters Cem. 2012 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville, MD. 21. Signature of Funeral Service Live 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home. P.A. Jarrettsville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition year Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami death certificate be executed bunial-transit Cause (Disease or iinjur) and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death signed by the a d be detached for Unknown Unknown • Hospital or Attending Physician: The law requires that the temple and they death.
• Funeral Director: After this certificate has been signed by the eted filled in by the funeral director, page 2 should be detached. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: မ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No injury 5 Pending Accident
Sulcide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🚉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29c. License number 34208 a a wals 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JARRETTSVILLE MO 2/084 NORRISVILLE RO, STEC, m AL WALSH

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2012

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6/23/2012^{Day} 10:46 A M Baby Boy A Pratt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Hours Days Director None 1 ¥ M 2 □ F 3 6/23/2012 Maryland Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 🔀 Yes 2 □ No MD Prince George's Bladensburg P 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 5510 Volta Ave. 20710 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. . or . 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Pratt, III Tobi Alexisse Penn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tobi Pratt / Mother 5510 Volta Ave., Bladensburg, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 6/29/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only or Immediate Cause (Final disease or condition Incompetent Cervix Physician/ resulting in death) Medical Due to (or as a consequence of): **Examiner** Premature Prolonged Ruptured Membranes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): IVF-infertility-Twins Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical cerclaged placed-Hx: Myomectomy for fibroids as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2♣ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: မ 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at, work? 28d. Describe how injury occurred eral Director: After filled in by the funer Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29b. Signature and title of co D71616 6/23/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) District Heights, MD e. 305 20747 Danielle Waldrop, M.D. Ste. 7610 Pennsylvania Ave.,

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year,

JUL 05 2012

68760

Box

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 28,2012 \mathbf{A}^{M} Raymond Q. Porter 1:24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. Director 225-22-2054 1 🕱 M 2 🗆 F Sept. 6,1926 Usual Residence of Decedent 85 Virginia 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1341 Meridian Place, North West 20010 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc 0 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 02/20/45 Year or Dates. 07/26/46 1 Yes 2 No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Painter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ray Porter Edna Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Patricia Porter/Daughter 7 Dawn View Court, Silver Spring, Maryland 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) 07/05/2012 Washington, District of Columbia 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Sign ture of Funeral Service Lic ase 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Chronic Renal Failure disease or condition Medical resulting in death) Examiner Congestive Heart Failure Sequentially list conditions Due to (or as a consequence of): If any leasing to in reclat cause. Enter Underlying Cause (Disease or injury that initiated events Exami Coagulopathy Due to (or as a consequence of): resulting in death) Last Physician/Medical Hypertension as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Clostridium Difficle, Pseudomonal UTI, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Mellitus Type 2 1 Yes 2 No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Tes 2 X No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 5+1 June 28,2012 D0068160 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com

DHMH 17 Rev 06-2011

State

Registrar

Kimberly Zuzak
B1. Date filed (Month, Day, Year)

JUL

05 2012

6/28/2012 0124A.M

8600 Old Georgetown Road, Bethesda, Maryland 20814

Gerald Dean Phillips

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		1- For State Certificate Certificate Certificate C		Reg. No.	12 2313
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 1618 hrs
odical Exami	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 9, 2012 4c. County of Death	
		1101 Glemsford Road # D	Essex	Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	- I	
Director		217-82-5785 1MM 2DF 47 Y	rs. Months Days Hours Min.	11-3-64	untry INDI ANA
b		Usual Residence of Decedent			10d. Inside City Limits
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Maryland 28a-f show d at once.	힗	10e, Street and Number	ESSEX 110f Zip Code	10g. Citizen of What Cou	
e - 2	Funeral Director		21221	U.S.1	
with the ns 23a be noti	<u>a</u>		vas Decedent of Hispanic Origin? (Sp	ecify Yes or No- 14. Race - Ameri	ican Indian, Black,
death or iten	in in	1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.	,
s after	ā	or Dates:	Yes 2 No specify:	Specify: (1)	DITE
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215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medics		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
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MD 21215-0036 2 should be filed within 72 27 is marked other than " 27 is marked other than " matte event, the Medical in	٩	O/ n t		Rural Route Number, City or Town, State	
				Date 20c. Location - City or	Town, State
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Baltimore permit. Pages 1 Department of F Important: If injury ar other		4 Donation 5 Other Specify: 21. Sig_ ure / Funeral Service Licensee 22.	Name and Address of Facility	16-12 ODENTON USHEATY FUNERAL A	I MD,
Balti permit. Departn Import		A) (John) MOOQ42 124	COL MOUNTAIN 100	. DASADENA, MD.	21/27
Physician		23a. Pirt I. Enter the use se, or concernitions that caused the death. Do not enter		n spiratory arrest, shock, or heart	Approximate Interval Between Onset and
iMedical Examiner		Immediate Cause (Final disease a Atherosclerotic Card	iovascular Diseas	se	Death
		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):			
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Box 687 ne death certific the attending p	Physician/	1 Yes 2 No 9 Unknown g Unknown	other (opecity)		
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Division tal or Attendi rs after death. al Director: A led in by the fu	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (Street and Number or Ru	ral Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, State)	
Division of Vital Records, P.O. Box 687 To the Hopital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director; After this certificate, has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investig and manner stated.			
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mor	ntn, Day, Year)
		Panile (Withell Ms)	O.O.IVI.E.	July 10, 2012	
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 90	00 W. Baltimore Street, Baltir	more, MD 21223	
S	ate				
Regis			<u>, </u>		
DHMH 17 Rev 1/2	001	ORIGIN	AL	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Russillo July 1, Victor D. 7:52 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 93 11/02/1918 Rhode Island Director 039-05-0477 XXM 2 F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director 1 Yes XX No Prince George's Ft. Washington Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 20744 USA 23a 752 Gleneagles Drive items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1. Marital Status Examiner Black, White, etc. ori þ 1 Never Married XX Married 1 ★ Xes 2 No within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed Year or Dates. WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Federal Government Foreign Serv. Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H ပ Piscitelli Domenica Filameno Russillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 752 Gleneagles Dr. Ft. Washington, Maryland 20744 Gloria M. Russillo / Wife 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State * ō 7/4/2012 Important: If any injury or once. Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityGeorge P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 21. Signature of Funeral Service Lices 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE RENAL FAILURE unknown disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** unknown DEHYDRATION Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Disa to for as a consucuence of unknown ATRIAL FIBRILLATION certificate be executed burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical OLD AGE unknown Division of Vital R cords, P.O. Box 68760 the as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy signed by the atte d be detached for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎛 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hyperlipidemia 24a. Was an autopsy performed lal or Attending Physician: The lars after death. al Director: After this certificate ha 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X XN0 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; 1XX Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 01 DOD 26262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 Livingston Rd. Ft. Washington, Samuel J. Kleiman MD20744 31. Date filed (Month, Day, Year) 32. Redistrar's Signature 05 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma		rtment of Hea		ental Hyg	iene	0112	2315
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Dea	atn T	2. Date of Deat	eg. No.	. 0 ; 2	2010
	Physicia		Marjorie Aleene Reed				Month July 2	Day	Year	3. Time of Death 6:03 P M
-	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	ation of Death	Sury 2	4c. Count		0.03
	Examin	Ϋ.	Wilson Health Care Center		Gaithers	burg		Mont	gomery	
	Funeral		5. Social Security Number 6. Sex 7. Age 1 □ M 2 🔀 F	(In yrs. last birthday) Q1 Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, OCt. 6,	Year)020	9. Birthplac Country) MISSOU	e (State or Foreign
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	and show i at	5	10a. State 10b. County	10c. City, Town or Loc					10d.	Inside City Limits
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DG 2	iled w Il Hyg I othe vent,	Be	17. Father's Name (First, Middle, Last)			. Mother's Name	(First, Middle, N	faiden Surnan	ne)	
ylar	Id be and Menta	욘	Phillip Adam Bergman			lary Ale				
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type, Print) Arthur F. Payne (Son)	19b. Mailin	ng Address (Street and I	Number or Rural	Route Number, Hughe	City or Town,	State, Zip Cod MD 20	637
e,	and 2 Health em 2:		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		ate		- City or Town	
Baltimore,			1 Burial 2 ☐ Cremation 3 ☐ Removal from State Graph of the control of the con	cemetery, cren	natory or other place) uls ery	July2	6		-	Maryland
əltir	permit. Page Department. Important: I any injury or		21. Signature of Funeral Service (Scense)	22	. Name and Address of	Facility DeV	ol Fune	ral Hor	ne,	
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Same of the Same	Medical Examiner		Due to (or as a	consequence of):						
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	ician: The certificate rector, pag		25. as case referred to mey cal	noma,	26 Place	of Death, (Check	1 \(\text{Yes} \)	2 No	1 Yes 2	∐ No
of Vital	ysician: is certific director,	To Be	examiner? Hospital:	ent 2 ER/Outpatier	Other	4 Nursing Ho		ence 6 🗆 Ot	her (Specify)	
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Division	I or Attenation after deat Director:	Cerl	4 Homicide determined 286, Place of Inju- building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (St City or Towr		per or Hurai HC	oute Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours affer death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	occured at the time, dat	te and place, and	d due to the cau	se(s) and man	ner as stated.	(a) and man =
	the Hk nin 24 the Fu	Med	(Check 2 Medical Examiner; On the basis of each only one) 3 Certifying Nurse Practioner: To the	kamination and/or inves best of my knowledge,	death occurred at the tim	ne, date and plac	e, and due to the	cause(s) and r	manner as state	d.
			29b. Signature and title of certifier		29c. License nu			,	ed (Month, Day	
	10		M. R. M. T Birschl	ndes.	04	RUSSE		Velle 11	22/20	1/2
-			30. Name and address of person who completed cause of d		A GAI	THERS	SUNO	o M	1 200	FMM
	Sta	te		ar's Signature	11	, , , , , , , , , , , , , , , , , , , ,		1	2000	'
	Registr	ar	JUL () 5 2012 Centure	B. 40	V					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death $10.29^{3.1}$ Time of Death a_{M} Physician/ 2012 Year $\operatorname{July}^{\mathsf{Month}}$ Ralph Henry Rosello Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 1 Year If Under 24 Hrs. If Under 8. Date of Birth April Day Yea 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) NY Days Hours Min. 079-26-3138 **Director** 77 1 X M 2 🗆 F Usual Residence of Deced 28a-f shov items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 3230 Hewitt Avenue, Unit 3 20906 **USA** within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Medical Examiner Black, White, etc 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates Korean "natural" Completed 3 Widowed 4 K Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 treent of Health and Mental Hygiene. tant: If item 27 is marked other than ' jury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Non-Profit Organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph A. Rosello Virginia Mejias 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3230 Hewitt Ave., Unit 3, Silver Spring, MD 20906 Ralph D. Rosello/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) $m July^{Date}~8$, 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o once, 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Colempud Address of FServices, P.A. 4110 Aspen Hill Road, #100, Rockville. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physiciani a <u>Atherosclerotic Coronary Artery Disease</u> yrs. Medical Examiner b Acute Myocardial Infarction yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Severe Congestive Heart Failure Exam mos. Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-trans Due to (or as a consequence of) Physician/Medical that the death certificate be Insulin-Dependent Diabetes Mellitus yrs. P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death the hed i Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obesity, Ischemic Cardiomyopathy, Chronic Kidney Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed Disease (Stage III) 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 2 Le No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2**X** No 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: (Month, Day, Year) 1 X Natural 5 Pending iniury death. after death.

Director: A
d in by the fi 2 Accident
3 Suicide Investigation M 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours af Funeral Di Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38159 July 2, 2012 Name and address of person who completed cause of death (Item Philip Charles Corcoran, MD 8 em 23a)(Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814

State

Registrar

31. Date filed (Month

Year) 9

2012

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ .THE Y 2012 **EDNA** RUTH ROBINSON 11:06 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CLINTON CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 578-36-8579 **Director** 1 □ M 2 🛣 F SENECA, SC 09/22/1926 Usual Residence of Deced 28a-f shov 10d Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No PG MD BOWIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 8312 RIVER PARK ROAD hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 XDivorced BLACK Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CLERK TYPIST and Mental Hygien GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, 2 BIRDIE GOODINE CHARLES BRADLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a :: If item 27 is 6805 RIVERDALE RD, #102, RIVERDALE, MD 20737 BENJAMIN ROBINSON/SON altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 s Department of Important: If it any injury or o cemetery, crematory or other place, XBurial 2 Cremation 3 Removal from State 7-7-2012 BRENTWOOD, MD 4 Donation 5 Other (Specify) LINCOLN CEMTERY 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Service Lic. nsee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Elnn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) FATAL ARRHYTEMIA Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consumence of death certificate be executed HYPERTENSION burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial Physician/Medical DEMENTIA Box 68760 attending IF FEMALE: use yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ģ Month Day Year Pregnant at time of death 1 Yes 2 No signed by the a d be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Records, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No 2 X No Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 XER/Outpatient 3 I DOA ျ 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniury 1X Natural 5 Pendina М Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 0 Hospital edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) KO88887 ett Dela ein DNACKUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAULETTE DELAPENHA, CRNP, 11217 LOCKWOOD DRIVE, SILVER SPRING, MD 20901

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 6 2012

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FRANKLIN JUN 2012 ROGERS 3:55Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WALTER REED NATIONAL MEDICAL CENTER BETHESDA MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Wash, DC 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min 578-42-7550 79 Director -30 - 193Usual Residence of Decedent show 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director PG notified MD Capitol Heights 28a-f 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be r Funeral 7007 Canyon Dr. 20743 U.S.A. . Page 1 and 2 should be filed within 72 hours after death virent of Health and Mental Hygiene.
tent if them 21 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. lury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 1952 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married X Yes Yes, Give Baltimore, Maryland 21215-0036 Black Year or Dates. 1974 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 1 2 life. DO NOT use retired) Government College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Walter E. Rogers Jennie Cary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Rogers (Wife) 7007 Canyon Dr. Capitol Heights MD. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ... 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State -24-2012 Arlington VA. 4 Donation 5 Other (Specify) Arlington Nat"1 21. Signature of Funeral Service Licer Name and Address of Facility Hunt Funeral Home 908 Kennedy St. Wash, D.C. 20011 5. Hunt + marcis CC353 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) **ASYSTOLE** Medical Due to (or as a consequence of) **Examiner** DIFFUSE LARGE B-CELL LYMPHOMA Sequentially list conditions. Examine Due to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No ည 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury X Natural 5 Pending 2 🗆 No Accident Investigation □ Acciden
 □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

EDWARDA M. BUDA, 31. Date filed (Month, Day, Year) JUL 0 6 2012

29b. Signature and title of certifie

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER

29c. License number

BETHESDA.

D20678

MD 20889

MD

29d. Date signed (Month, Day, Year) JUN 29 2012

12-05260	Ple	ease Ty	pe or Print i	n Black Inde	elible In	k. Ens	sure	All Co	pies	Are Legib	ile.			
Darlene Susan Roa		Si	ate of Maryla	and / Depart	ment of	Health	and	Menta	al Hy	giene	2	012	231	
	1- For State Registrar			Certif	icate of	Death				Reg. N	lo.	012	201	~
Physician/ Medical Examiner	Decedent's Nam			san	Roa	ch				2. Date of Death Month Da July 12, 2012	y Year		ime of Death 238 hrs	
	4a. Facility Name (on, give street and n	umber)	4	b. City, Tov Cumbe		cation of	Death		4c. County of Allegany	Death		
Funeral Director	5. Social Security I		6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	_	8. Date of Birth(N 06/24/19		9. Birthplac Foreign M Country	e (State or laryland	
	Usual Residence	f Decedent				<u> </u>								_
·land ·f show any once.	10a. State MD	10b. County A	llegany	10c. City, To	wn or Location	erlan	d						Inside City Limit	
a + 11 7	1 - 01 - 1 - 111					10f Zin C	odo			10a	Citizen of Wh	at Country?		-

10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27, it marked other than "natural", or items 23a or 28a-injury or other tranmatic event; the Nicoleal Examiner must be notified at injury or other tranmatic event; the Nicoleal Examiner must be notified at USA 21502 131 Arch Street, Apt 1 14. Race - American Indian, 8lack, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 1 Never Married 2 X No Yes Specify: White 1 Yes 2 No specify: 4 X Divorced If Yes, Give Year Š 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cornpleted Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname)
Melanie (NMN) 17. Father's Name (First, Middle, Last) Wilmot Allen Singleton Melanie Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 247 Centerville Road, Bedford, PA Melanie Humbertson / Mother 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 K Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/16/2012 Cumberland, MD Cumberland Crematory Donation 5 Other Specify 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Fune all Service Licensee 21502 404 Decatur Street, Cumberland, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Death failure. List only one cause on each line. /Medical aOxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and ician/Medical AMENDED 23a, 27, 28a-f, per me, g929 7-27-12 sm X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Day Live birth Year 3 Ectopic pregnancy Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown certificate has been signed by the ector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 1 Yes 2 No 3 Probably 4 Volknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 Yes 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun 1 Natural unknown 1 Yes 2 X No Pending fd 7-10-12 fd 10:15 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Arch St.
Cumberland, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 13, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner

Laron Locke MD. 31. Date filed (Month, Day, Year)

OCME

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 Year JULY MARY ELIZABETH STINCHCOMB 6:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S **GRASONVILLE** 910 LONG POINT ROAD Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours (Month, Day, Year, Director 1 🗆 M 2 🕱 F 87 215-24-4076 Yrs MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No **GRASONVILLE QUEEN ANNE'S** MD 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be Funeral 21638 910 LONG POINT ROAD USA items Page 1 and 2 should be filed within 72 hours after death ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working) 16b. Kind of Business/Industry life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 12 -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **BLANCHE ROYSTON** ADDISON FOSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 LONG POINT ROAD, GRASONVILLE, MD 21638 DOUGLAS W.STINCHCOMB/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. CHESAPEAKE CREMATION JULY 3, STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Funeral Service FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) 1 mm Un Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ò in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has page 2 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred s after death. Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

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rson who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Year 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Year DENNIS EDWIN SUMMERS JUL 2012 5:05 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WALTER REED NATIONAL MEDICAL CENTER **BETHESDA** MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours Min Sept. 30, 1951 60 Arkansas **Director** 465-96-1270 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director Gaithersburg Montgomery 28a-f Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code rms 23a or ō 10g. Citizen of What Country? Funeral 15103 Gravenstein Way 20878 United States items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner rmed Forces?
No 1986-Black, White, etc. ò 1 Never Married 2 Married X Yes ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 2012 Specify: "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) United States Navy Pathologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John Edwin Summers Mary Jane Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Graciela Summers (Spouse) 15103 Gravenstein Way, Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 6, 1 Burial 2 X Cremation 3 Removal from State cemeter compator ir cher place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Crematory Alexandria, Virginia Signature of Funeral Ser 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 23a. Part Monter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death RESPIRATORY FAILURE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LUNG CANCER Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): ding physician Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day Year Pregnant at time of death 5 Other (specify) signed by the al d be detached fo 1 | Yes 2 | g | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? this certificate 2 No 1 Yes • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 **X**No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending injury 1 Yes 2 No Accident Investigation ompleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VA 0101236858 JUL 03 2012

Registrar

State

CARTER,

05 2012

MD

COREY A.

31. Date filed (Month, Day, Year)

JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER

BETHESDA, MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month July 2012 рм Evelyn Lear 7:30 Stewart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Rehab. and Nursing Ctr. Sandy Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Country) 075-22-2873 Director 1 □ M 2 T F Jan. 8, 1926 New York 27 is marked other than "netural", or items 23a or 28e-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15101 Rosecroft Road 20853 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc., White Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3[™] Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Music Opera Singer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nathan Shulman Nina Kwartin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Jan Stewart/Son 3413 Olandwood Court, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any Injury or ot July 2, 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Stroke months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end
completely filled in by the funeral director, page 2 should be detached for use as the burial transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Breast Cancer, Hypertension, Hypercholesterol 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 🖾 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005 July 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Anuradha Arun, MD

05

2012

31. Date filed (Month, Day, Year)

32 Registrar's Signa

10301 Georgia Avenue, Silver Spring, MD 20902

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ez State of Maryland / Department of Health and Mental Hygiene 2012 23 6

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	and show	٥	Md	Princ	ce Geor	ge	Hya	ttsville							1 Yes 2 No
	h the Maryl 3a or 28a-1 otified at o	Director	10e. Street and Nur 5919 Ex	mber dmonstor					Zip Code 20781				Hon	n of What Cour duras	
	EXAMPLE OFF. MID 21213—0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marrie 3 Widowed						ecify Cuba	ın, Mexican,	gin? (Specify , Puerto Rica Hondu	n, etc.)		4. Race - Americ White, etc. pecify: H1S	can Indian, Black,
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6	LIVISION OF VITAL RECORDS, P. O. BOX 68 / 60, 1s afor Attending Physician: The law requires that the death certificate be executed. 1s afor death. 2a Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/	past 12 months	?	4 Pr	egnant at tim nknown	ne of death	2 Fetal de			pregnancy			Sitti D	ay icai
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	2	Me	29b. Signature and	title of certifier	1	. ^				se number				ate signed (Mor	th, Day, Year)
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			30. Name and address Pamela E. S	Southall, MD) Assista			ner 900 W.	Baltimo	re Street	, Baltimor	e, MD 21	223		•
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Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ :38 AM Frazer Randolph Sheets 3rd 28 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death Examiner 500 CULLER AVE Frederick Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 115402988 Director 61 May 11 1950 New YOVIC show 10c. City, Town or Location must be notified at **Funeral Director** 28a-f 1 Yes 2 No Maryland Frederich Frederick 10e. Street and Number ö 10g. Citizen of What Country? 23a 21701 Culler Avenue unika States 500 items death 1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc 10 1 Never Married 2 Married by Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 🗆 Yes 2 🗖 No Specify "natural", Specify: Completed 3 Divorced White Year or Dates. Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Montg Co school Board Elementary/Secondary (0-12) College (1-4 or 5+) Teacher other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked of ၉ Frazer R. Sheets Rila Morgan and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8th St, Apt Ab (brother Health a 553 Erik Sheets Brooklyn NY item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State - of -1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Smithsburg Cremetory June 30,2012 Smithsburg Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility suy 110 W South St, PO BOX 3500 Frederick MD 27705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) es Medical Examiner Sequentially list conditions. ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 L Yes 2 L 9 D Unknown 9 Unknown to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contrib 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director; After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 🚅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Registrar's Signatur State about Registrar

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	ntic General I	Hospital 7. Age (In yrs. la.		Ber. If Under 1 Year		rs. 8. Date of Bir	Worce	ester 9. Birthplace (State of	r Foreign
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Division of the Hospital or Attending Physics of the Hospital or Attending Physics of the Hospital or Attending Physics of the Hospital Order of the Homeral	1 Certifying Physician: To the 2 Medical Examiner: On the	ne best of my knowle basis of examination	edge, death o and/or investi	ccurred at the time	e, date and place on, death occurr	ce, and due to the co	ause(s) and mani	ner as stated. le to the cause(s) and mar	nner stated.
only one) 29b. Signature	Certifying Nurse Practition and title of certifier	oner: To the best of m	y knowledge,	death occurred at t 29c, License		id place, and due to		manner as stated. d (Month, Day, Year)	
	NIL					4			
BA 12	address of person who completed o	cause of death (Item)	23a) (Type, Pi	rint) 115 5-	DIVSIUN	SVEW	SAUSO	7/3/2 UMy MB 2	1804
State 31. Date filed (f Registrar	JUL 0 5 2012	2. Pegistrar's Signatu	d. do	115 5-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5:50 PM 201. Anc Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Aldort WAWORF If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Hours Min Vrs Director Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No 10e, Street and Number 10f, Zip Code ò 10g, Citizen of What Country? event, the Medical Examiner must be Funeral 23a USA 2070 items ? 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ō þ ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify and Mental Hygiene.
is marked other than "natural", Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DRIVATE Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Saunders 0410 20701-1152 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ö cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wordbridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat warrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Por Month Day Year Pregnant at time of death 5 Other (specify) the detached Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signs completed filled in by the funeral director, page 2 should be a Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural work? 5 \square Pending 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, Jesti. d at the time, date and place, and due to the cause(s) and mariner as status 29b. Signature and title 29d. Date signed (Month, Day, Year) 2 32. Registrar's Signature

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Smith Lee Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC Birthplace (State or Foreign Country)
 PA f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 6 Sex Social Security Number **Funeral** Aug 30, 1925 Hours 1 XM 2 🗆 F 86 189-20-8415 **Director** Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland **Funeral Director** Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 14100 Canal Ferry Rd SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: white WW II 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) I Hygiene. other than ' life DO NOT use retired) Elementary/Secondary (0-12) Law Firm Attornev Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olga B. Blum ည Stanlev Oliver Smith and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14100 Canal Ferry Rd SE Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 Sandra Smith wife and 2 s Health tem 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Xremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 7/11/201 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address III Full Eral Home, PA of Funeral Se vic 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE DAYS .Ph sician/ FOUN disease or condition resulting in death) Medical Examiner STAGE CIPTORIC UBSTRUCTIVE PULMONARY YOUR Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician; The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy has 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after deau... he Funeral Director: After this ce notetely filled in by the funeral dire 2 XNo 잍 1 Yes 1 XInpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and ti DUC33417/MARZUAND JULY 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1068 NATIONAL HIGHWAY LAVACE, MANICAMO 21502 MOEN 40 AMES R. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ July 2012^{ear} Janet B. Stello 17:58P. м Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery 4b. City, Town, or Location of Death Examiner Silver Spring 3122 Gracefield Road, #512 7. Age (In yrs. last birthday) 92 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 219-01-2260 1 M 2 X F Months Days Hours Min. JUN 28% 1919 Pennsylvania Director Usual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 🖰 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 United States Funeral 3122 Gracefield Road, #512 within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mente Important if item 27 is marked any injury or other traumation once. ဂ Agnes Crawford Bret H. Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21125 Cardinal Pond Terrace, #420 Ashburn, VA 20147 Janet S. Menassa -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Md. National Mem. Park 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 7/9/2012 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donaldov.dorBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Md. 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Myelodysplasia Medical resulting in death) Due to (or as a consequence of) Examiner years Diabetes Mellitus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b, Time of 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature July 5, 2012 D24035 m 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.S. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) **JUL 2 0 2012** 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7/2/2012 Physician/ Frederick Jacob Trojan 4:43 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Salisbury Wicomico 30639 Satterfield Ct. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign MD Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1**¥** M 2 □ F 65 1071871946 Director 217 44 1291 ms 23a or 28a-f shov must be notified at 10a. State 10c. Citv. Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 📉 No MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 30639 Satterfield Ct. ral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. Army Specify: White "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Corrections Officer Somerset County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alfred Jacob Trojan Elizabeth Louise Mumford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Trojan (wife) 30639 Satterfield Ct. Salisbury, MD 21804 : If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: I any injury or Sunset Memorial Park 7/7/2012 Berlin, MD 4 Donation 5 D Other (Specify) 22. Name and Address of Facility 21. Signature Service Licens The Burbage Funeral Home 108 William St. Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Guller disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 1 Yes 2 L 9 Unknown been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has to autopsy Be 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) 047094

Registrar
DHMH 17 Rev 7/2009

State

BA 5+1

1415

5 DIVISION

Sheet

NATESAN

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 0 5 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene

2012 23168

		- For State Certificate of Death		Reg. No.	2012 2010
Physician ledical Examine	/ 1	1. Decedent's Name (First, Middle,Last) WALTER CLIFTON TAYLOR	2. Date of De Month July 7, 20	Day 12	3. Time of Death 1813 hrs
	4	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center 4b. City, Town, or Location of Death Belair		Har	
Funeral Director	- 1	5. Social Security Number 6. Sex 1. Months Days Hours Min.	4	11/19	YYYYY) 9. Birthplace (State or Foreign Country) MD
nd haw any ce.	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location PA York Delta			10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a nr 28a-f shnw notified at once.	olpanici 1	10e. Street and Number 10f. Zip Code 17314			of What Country? USA
er death wi	-nue	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No specify: 1 Yes 2 No specify:	Rican, etc.)	Sp	Race - American Indian, Black, White, etc. White ecify: I of Business/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Isnet: If item 27 is marked inther than "natur or other traumatic event, the Medical Exam	шріетеа	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Sheet Metal Fabrica	ed) .tor	Co	nstruction
ore, MD 21215-0036 es 1 and 2 should be filed within 7 of Health and Mental Hygene. If item 27 is marked atther than the frame after cent, the Model of the filed of the file	n n		lizak	eth '	Wheatly
MD 21 nd 2 should alth and Me m 27 is ma aumatic cv	1	19a. Informant's Name/Relationship (Type, Print) Brenda M. Taylor/Wife 20a. Method of Disposition 19b. Mailing Address (Street and Number or Right Street) 302 Chestnut Street) 20b. Place of Disposition (Name of cemetery,		elta,	
Baltimore, ME sernit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traum.		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specific Slate Ridge Cem. 7/1	1/12		lta, PA
	1	21. Signature of Juneral Service Ice 22. Name and Address of Facility Harkins Funeral 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			
Physician /Medical miner		pailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and Death
	mine	Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last			
execul an and al - tra	/Medical Ex	d. UNPENDED AMENDED	-		
68 certif	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of 5 Other (Specify)	ncy		Date of delivery onth Day Year
P.C es that igned l	≥	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e contribute to the cause of death?
of Vital Records, P.O. Box by Private and Prysician: The law requires that the death there is certificate has been signed by the attendant director, page 2 should be detached for uneral director, page 2 should be detached for	Completed		pe	as an topsy formed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	Ğ Be	25. Was case referred to medical 26.Place of Death (Check of D	only one)		
Vita hysici this ca	<u>.</u> eL	1 Yes 2 No	g Home 5	Residence	
Division of Vital ospital nr Attending Physician: hours after death. nueral Director: After this certifi ly filled in by the funeral director.		Natural 5 Pending Pound. 1 Yes 2 No 1630 hrs	Subject e temperatu	ire	high environmental
Division ospital nr Attendi hours after death.	Certification:	4 Homicide	or Towr Chestnut S	, State) treet, Delta	
To the Hos within 24 ho To the Fun completely	dical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the ca	ate and place	e, and due to the cause(s)
	_	29b. Signature and title of certifier 29c. License number O.C.M.E.			ate signed (Month, Day, Year) 3, 2012
10 BW		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltin	nore, MD	21223	
Sta Regist	,,,,				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 5:00 A VLADILENA TOLLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Corbett Village Lane Monkton Baltimore 8. Date of Birth (Month, Day,) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Min. Months Davs Hours Country) 225-36-1978 90 **Director** Russia Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD. Baltimore Monkton 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral items 23a 16205 Corbett Village Lane 21111 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or þ 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Professor College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rabinovich Rimma Ismah Lvovna Gritzenko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any Injury or other trau once. (Daughter) Wine Spring Garth T. Franke Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 15 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. 2012 James Cemetery Monkton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland P.A Home. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. 0,000 disease or condition resulting in death) 12 avs Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nujse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number luy 13 2012 1357169 20 pm address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ar

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

CW

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland		rtment of H		, 0			
			Registrar 1. Decedent's Name (First, Middle, Las	t)	007	incate of D	Catri	2. Date of Death	g. No.	U 1 2 2	of Death
	Physicia Medic		Carol Le	ee Wright				July	1,2012	2 ^{Year} 12:	53p M
The second	Examir		4a. Facility Name (if not institution, give Shady Grove	street and number)		4b. City, Town, or	Location of Death	***************************************	4c. County		
egent.	Funeral		5. Social Security Number 6. Se		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	11011	Birthplace (State	e or Foreign
	Director		214-60-1007	□м 2№	Yrs.	Months Days	Hours Min.	7 1637	53	Marylan	
	iland f show d at	ţō	10a. State 10b. County		, Town or Loc						City Limits
	r 28a-i notifie	Direc	MD Montgor 10e. Street and Number	nery S		Spring					Yes 2 No
	n with the is 23a o	neral	12914 Flack St	reet		10f. Zip Code 20	906	10	g. Citizen of V	USA	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		/as Decedent of His Yes, specify Cuban ☐ Yes 2 X No		ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. White	
15-(72 hou In "natu Medica	nplet	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	ent's Usual Occupa ind of work done du NOT use retired)		ing 1	6b. Kind of Bu	siness/Industry	
212	l within ygiene. ner tha t, the l	e Cor	Elementary/Secondary (0-12)	College (1-4 or 5+)		gal Ass	istant		Mort	gage Co.	
Baltimore, Maryland	l be fileo lental H rked otl tic even	To Be	17. Father's Name (First, Middle, Last) John Walter	Bendinskis			18. Mother's Nam Lena	e (First, Middle, Ma Lunett	iden Surname a)	
Mary	2 should h and N 7 is ma traumat		19a. Informant's Name/Relationship (Ty George Dale Wr.			Address (Street ar					20006
re,	f Healt item 2 other		20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of				ing, Md 2 City or Town, State	
timo	. Page tment c tant: If jury or		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			atory or other place ake Cre		/2012	Belts	ville,Mo	1
Bal	permit Depart Impor any in once.		21. Signatur of Funeral Service Lens	³⁶ Q	PH 92	Trepard Address 41 Colu	RTNALDI mbia Bl	FUNERA	L SER	VICE, P. A	A. 20910
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	. Do not ente					Approxin Interval E Onset an	nate Between
	Physician Medical Examiner		disease or condition resulting in death)	a. Sepsis Due to (or all a conseque	ence of):					8 4	reck
	Examiner	er	Sequentially list conditions,	b. Priton						1 in	reek
	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Ovariar		ncer				mo	nths
0	ate be executed hysician and the burnet transit	dical E	resulting in death) Last	Due to (or as a conseque	ence of):						,,,
68760	tificate ng phys	Medi	IF FEMALE:	d	VT						
Box 6	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the bunelitansi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ► No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de g ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day	Year
ls, P.O.	uires that the dea n signed by the a uld be detached	by	Part II. Other significant conditions co	ntributing to death but not resul	Iting in the ur	derlying cause give	n in Part I.			bute to the cause of	
of Vital Records,	las been si	Completed						24a. Was an autopsy	24b. W	/ere autopsy finding	s available f cause of
l Re	ician: The law certificate has rector, page 2		25. Was case referred to medical			40.5		performe		eath?	
Vita	ysician: is certific director,	To Be	examiner?	Hospital:	B/Outpatient	Othor	e of Death (Check	me 5 Residence	co 6 🗆 Othor	(Speciful	
Jou	ing Ph		27. Manner of Death 1 XNatural 5 ☐ Pending		28b. Time of injury	28c. Injury a work?	at ;	28d. Describe how			
Division	Attending P r death. ector: After t by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom	ne, farm, stree		es 2 No	28f. Location (Stree	et and Number	r or Rural Route Nur	mber.
N	vital or urs afte ral Dire			building, etc. (Specify)				City or Town, S	State)		
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check 2 \(\sum \) Medical Examir	ician: To the best of my knowled ner: On the basis of examination a e Practitioner: To the best of my	and/or investi	ation, in my opinion	death occurred at	the time, date and i	place and due	to the cause(s) and r	nanner stated.
_	To the P within 2. To the F complet		29b. Signature and title of certifier			29c. License r	number	290	I. Date signed	(Month, Day, Year)	
	l			nengro	20-1 (7)		44		July	1,2012	
			30. Name and address of person who co	9901 Medic	, , , , ,	ter Drive	ROCKVI	lle MD	20850)	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) JUL 0 5 2012	32. Registrar's Signatur	re face			- 1 - 2 -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ise Physician/ Month a.ze Medical 07/01 /2012 10:50 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis House Health Center Waldorf Charles 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign MBountry) 219-28-8762 1 🗆 M 2 🔀 F Months Min. Hours 91 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Howard Columbia 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6610 Cedar Lane 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ŏ ò 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 __ Yes If Yes, Give Year or Dates 1 Yes 2X No Specify: 'natural", 3 X Widowed 4 ☐ Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Page 1 and 2 should be Walter L. Dorsey Mary Emma Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Thelma Bernette /daughter 3409 Halloway N., Upper Marlboro, MD 20772 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Locust UMC Cemetery injury (7/7/2012 4 Donation 5 Other (Specify) Columbia, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service Ocensee any 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): brillation Examiner \mathcal{O} Sequentially list conditions, Physician/Medical Examine cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician buri Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ģ 5 Other (specify) Month Year Day Pregnant at time of death 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached a 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural work? 5 Pending iniury 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 71199 10 npleted cause of plan Printion Bludstes, eath (Item 23a) Type, VSSIINVO2

Registrar

State

31. Date filed (

Day, Year) 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 30^{Pay} Physician/ 20 Î 2 8:15 p. M Eva Santos Washington June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Glade Valley Center Walkersville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 046-26-1243 Usual Residence of Dec 1 □ M 2 🕅 F 78 Connecticut 07/20/1933 show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits the Maryland **Funeral Director** notified 28a-f s 1 Yes 2 X No MD Frederick Frederick 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 7313 Westwood Drive 21701 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner i Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Program Analyst of Health and Mental Hygi fitem 27 is marked other r other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Oveido Santos Ida May Gay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelia Washington / daughter 7313 Westwood Drive, Frederick, MD 21701 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 5 Department of Important: If any injury or once, 7/4/2012 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, 21. Signature of Funeral Service Licenses proudu 16reh MO1222 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year signed by the at d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe 24 hours after death. Funeral Director: After this certificate 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 9 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending iniury Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F the only one)

State Registrar 29b. Signatule and title

32. Registrar's Signature

5

who completed cause of death (Item 23a) Type, Peint D DLIVE FRED EXICK

Barks

D26516

29d. Date signed (Month, Day, Year,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Physician/ 2012 Audrey Mabel Whitehead 29 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 226 Timberline Rd. Berlin Worcester Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 7 /25 /1922 1 M 2X F Min Country) 89 Yrs. Director 216-16-3935 MD Usual Residence of Decedent 10a. State 10b. County 28a-f shor 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 Yes 2 No MD Worcester Berlin 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 226 Timberline Rd 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner W WtL MCICI A Baltimore, Maryland 21215-0036 Black, White, etc ö þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Specify white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ is marked John F. Murphy Mabel Edith O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Dicken / daughter 226 Timberline Rd., Berlin, MD 21811 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State First State Crem. 7/3/2012 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) of Fune al Service Licen 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 Pregnant at time of death Month Day Year signed by the a Hospital or Attending Physician: The law requires that the 24 hours after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has perform Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum_{\text{Nursing Home}}\) ျပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred After Natural 5 \square Pending injury Accident Investigation 2 🗌 No 24 hours after deat Funeral Director completed filled in by the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29d. Date signed (Month, Day, Year) address of person who completed cause of death BA 3 Solich State JUL 0 5 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ argaret 5:108 M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, **Director** 217 07 0365 1 M 2 TF Yrs 93 10/09/1918 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ural", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Ellicott City MD Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 9998 Old Annapolis Road 21042 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White Yes, Give 1 🗌 Yes 2 🔀 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natur inv or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Cook Bon Secour Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Joseph M.C. King Mary Magdelene Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Jay Drive Ellicott City,MD 21042 Joseph Zentgraf/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Crest Lawn Mem. 7/9/2012 Marriottsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilitHarry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia Stau nd disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Pregnant at time of death Month Day Year signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Decubitus Ul Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate I completely filled in by the funeral director, pag 2 \square No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 10053337 52012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greencustle Burtonsville 3415 Load egistrar's Signature State

Registrar

DHMH 17 Rev 06-2011

12-05316	
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5316		Please Type or Print in Black Indelible amend 17 per fh. 993 State of Maryland? Department	Ink. Ensure All Copie	es Are Legible.	12 231					
e Anders		1-For State Registrar Certificate		Reg. No.	12 231					
ian/ Med Exam		Decedent's Name (First, Middle,Last) Donte Anderson		2. Date of Death Month Day Year July 15, 2012	3. Time of Death 0621 hrs					
		4a. Facility Name (if not institution, give street and number) Northwest Hospital	4b. City, Town, or Location of Death Randallstown	4c. County of Deal Baltimore Co						
Funeral Director			If Under 1 Year If Under 24Hrs Months Days Hours Min.	1 0	irthplace (State or Foreign ountry) aryland					
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i with the Mary land ms 23a or 28a-f show any <u>be notified at once.</u>	Director	MD Baltimore CO. 10e. Street and Number	Owings Mills 10f. Zip Code	10g. Citizen of What Cou						
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ter dearn wu ", or items ; er must be n	/ Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto Yes 2 🔀 No specify:	Rican, etc.) White, etc.	Black					
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and Me	မှ	19a. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State Apt 3C, Owings						
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permit. Es Departme Importan injury or		21. Signature of Funeral Service Licensee	osephors Brown 140 N. Fulton	Jr. Funeral Hor Ave., Baltimore	ne PA					
ysician Vedical aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The to (or as a consequence of):		respiratory arrest, shock, or heert	Approximate Interval Between Onset and Death					
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ures that the signed by the detached	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the Asthma	underlying cause given in Part I.	23e. Did tobecco use contribute to	the cause of death?					
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nysician: this certif I director,	To Be C	25. Was case referred to medicel examiner? 1 X Yes 2 No Hospitel: 1 Inpatient 2 X ER/Outpatie		only one) ng Home 5 Residence 6 Othe						
Attending Fi is death. ector: After by the functain	ation:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Death 28a. Date of Injury - At home, farm, significant and the Death 28a. Date of Injury - At home, farm, significant and the Death 28a. Date of Injury - At home, farm, significant and the Death 28a. Date of Injury (Month, Day, Year)	1 Yes 2 No	28d. Describe how injury occurred 28f. Location (Street and Number or R	ural Route Number, City					
	al Certifi	Suicide Could not be determined (Specify) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occ	surred at the time, date and place, and c	or Town, State) due to the cause(s) and manner as state	d					
To the Hosp within 24 ho To the Fune completely fi	Medical	29b. Signature and title of certifier	29c. License number	29d. Date signed (M						
/	1 1	Throdis M. King Th., un. 1 30 Name and address of pirson to completed calle of death (if m 23a)	O.C.M.E. DOWN							
		Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street, Bal	uniole, MD 21223						

State 31 Date filed (Month, Dev, Year) 3 2012 32 Red Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner AACO 353 Metropolitan Blvd If Under 24 Hrs. 9. Birthplace (State or Foreign MARy / Mhy If Under 1 Year Date of Birth (Month, Day) Social Security Number 6. Sex Age (In yrs. last birthday) Funeral Hours Min. Months Days 1 M 2 3 2/14/30 82 Director 213-26=6407 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Xes 2 No items 23a or 28a-f shiner must be notified Director **AACO** Md. Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with U.S.A 353 Metropolitan Blvd 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☑ No Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates: er than "natur , the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Iem 27 is marked other than other traumatic event, the M AACO Dept Of School 4 School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hall 2 Clarence Hall Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 6440 Miami Ave, Glen Burnie, Md. Bruce Anderson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if iter
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/17/12 Mt.Zion Cem Pasadena, Md. 21. Signature of Funeral Se rvice Licensee Entan-Pl 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A proximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATI **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No by the 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No ector. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21061 (GLEN BURNIE) LGOO CRAIN HWY, SUITE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 012 July Mae 20 8:45 PM Beers Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours 213 20 7520 10/17/1923 1 🗆 M 2 🔀 F Pennsylvania Director 88 Usual Residence of Decedent show 10b. County 10a, State death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Baltimore Essex 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21221 United States 314 Magnolia Terrace 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the <u>Medical Exami</u>n 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Crown Cork & Seal Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Eva Rhoads ဥ Cecerge George Beers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Magnolia Terrace Essex Maryland 21221 Esther Jane Beers (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Ind 7/23/2012 Baltimore Maryland 21 of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ho Immediate Cause (Fi Cause (Final Physician/ CEREBROVASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical use as the ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 X No 9 Unknown 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

Funeral Director: After this certificate has I autopsy perform Yes 2 K No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending injury Division 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and ti e of ce 29c. License number 29d. Date signed (Month, Day, Year) 2012 () 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year 32. Registrar's Signature State JUL Registrar

LEAH BEERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month yward JV. 012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ne John timore Social Security Number 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Months Days Hours 053-36-2935 Director 1 ፟ M 2 □ F 67 May 17, 1945 New York ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA FAirfax Springfield 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7915 Richfield Road 22153 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: "natural" Specify: 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Nuclear Physicist Nuclear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) ၉ Edward J. Bentz, Sr. Josephine Costagliola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Bentz 7915 Richfield Road, Springfield, VA Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any Injury or ot 20c. Location - City or Town, State 1 X Bunal 2 Cremation 3 Removal from State cemetery, crematory or other place)
Musconetcong Valley
Cemetery 4 Donation 5 Other (Specify) 7-23-2012 Hampton, NJ 21. Signature of Funeral Service Ligenses Metropolitan Funeral Service 22. Name and Address of Facility 5517 Vine Street, Alexandria, VA 2da. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest anock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending phoched yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown <u>P</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 No 1 Yes or Attending Physician: hours after death. Ineral Director: After this certifically filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 🗆 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral I Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) HUGHES Ba Himore, HD 1900 Orleans Street.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar	State of Maryland		artment of H rtificate of I			ne 012	23179
I	Physicia		1. Decedent's Name (First, Middle, Last)	rome Ba	rest	+		2. Date of Death Month	Day Year	3. Time of Death \$\int_{.10} A_{.M}.
	/Medic Examin Funeral	er	4a . Facility Name (If of institution, give st	reet and number) 7. Age (In yrs. le	ast birthday)	4b. City, Town, or	Location of Death OF 2 If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 08/07/19	4c. County of Dea	thplace (State or Foreign
	Director	-	212-26-8433	M 2□F 81	Yrs.			08/07/19	30	MD
	ryland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or itams 23a or 28a-f show any injury or other traumatic event, the Madical Exercitivat Institute it citified at once.	Director	MD N/A 10e. Street and Number	Balt	timore	10f. Zip Code		100	. Citizen of What C	
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980		by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1951			ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify	
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worki f)	ng 16	6b. Kind of Business	/Industry
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and		Be	17. Father's Name (First, Middle, Last)		Barı	-att	18. Mother's Name Mildred	i (First, Middle, Ma	uden Sumame)	Williams
Maryland		2	Ernest 19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street	and Number or Rura			
			Diane F. Barrett,		_		n Lane, Fo	the state of the s		
Baltimore,			20a. Method of Disposition 1 ™ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	rison	osition (Name of matory or other place Forest	07/2	7/12 0	wings Mil	ls, MD
Balt			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214							214
Т			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death e cause on each line.	n. Do not en				t,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	uence of):	/ may	illary.	Sinus		inskucions
ds, P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Juner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
		dical Examiner	that initiated events resulting in death) Last	C						
		Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23d. Date of d Month	elivery Day Year
		d by Ph						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown		
Records,		Complete						24a. Was an autopsy perform	prior to	
Vital	Physicien: The la this certificate ha ral director, page (a	Be	25. Was case referred to medical 26. Place of Death Check onlone examiner?							
of	ng Phy fer this	tlan; To	1 Yes 2 No 27. Manyer of Death 1 Natural 5 Pending	1 Vinpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	4 Nursing no	ame 5 ∐ Resider 28d. Describe hov		есту)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Affer completely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	be One Blace of Injury. At home form street feetons office.				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		Medical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
	Nam		4. (ah) m.D. 34354(0410) 914 12							
	2+ 0'		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Tohn S. Lahm, D. 3900 Loch Rayen Bonds vard, Baltimera, In any final 21218 31. Date filed (Month, Day, Year) 32. Registrates Signature							
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra 's Sign	Jak.		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ BROWN Month LADU 2012 0850 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. Gounty of Death A01 PITAL Itmore 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Hours Country) Director 1 M 2 F 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 Yes 2 No mDBaltimore 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral Kenwood Ave 21213 USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4 or 5+) 2+h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Eatherlene Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltomo 21229 Karen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donaylon 5 ☐ Other (Spacify) rison Forest Signature of Fune al 3 rvis 22. Name and Address of Facility 21229 70 Fredhilton Hass Balto. MD Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ THEROSCLERONC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy j Month Pregnant at time of death 5 Other (specify) Dav Year detached the 9 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director; After this certificate has I completely filled in by the funeral director, page 2: perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 1800 ORLEANS State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July ^{Day} 2012 Donald Brown 19 5:53 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1908 Queensway Dundalk Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Hours Min. Month Day, Year) 1**9** 12, 1922 **Director** 216-16-5781 90 Pennsylvania May Usual Residence of Decedent show 10b. County 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country? Funeral 1908 Queensway 21222 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1▲ Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than " r traumatic event, the Mec Maryland Air Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Maintenance 12 years National Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Hector Brown Susie Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Brown wife 1908 Queensway, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 23, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, Maryland 2012 Signature of Funeral Servi 22 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 1176 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sbock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ocandi Achte disease or condition mi Medical resulting in death) Due to (or as a consequence of): **Examiner** 620 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and l-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy The law requires that the death in the past 12 months? Pregnant at time of death Month Day Year 2 No the 9 Unknown Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 death? certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 100 Other: ဂ္ 1 Yes nin 24 hours after death.

the Funeral Director: After this in a properted filled in by the funeral diin the 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident Suicide М 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one)

Registrar DHMH 17 Rev 7/2009

State

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29b. Signature and title of certifie

a,

lacel

Samara,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 East

29c. License number

52016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

evonte Bowma		State of Maryland / Department of Certificate of			201	2 23 18
Physicia	ın/	1. Decedent's Name (First, Middle,Last)		2. Date of Deat		3. Time of Death
edical Examin	ner	Devonte' Lezander Jamal		July 14, 20		0643 hrs
j		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Deat Baltimore	h	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	_	th(MM/DD/YYYY) 9. Bird	
Director		212-35-7538 1XM 2 F 20 Yrs	Months Days Hours Min	12 2	26 91 Foreig	n MD
any .		Usual Residence of Decedent 1Da. State 1Db. County 10c. City, Town or Locati	on	•		10d. Inside City Limits
* .		MD NA Baltimo				1 X Yes 2 No
Maryland 28a-f show d at once.	ğ	10e. Street and Number	10f. Zip Code	. 10	0g. Citizen of What Cour	ntry?
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Funeral Director	2536 Edgecomb Circle North #K	21215		U.S.A.	
th with	Jera	1 Never Married 2 Married Armed Forces? If Y	s Decedent of Hispanic Origin? (See, specify Cuban, Mexican, Puert		- 14. Race - Ameri White, etc.	can Indian, Black,
9 5 8		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: Bla	ack
ours af atural xamin	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	t's Usual Occupation (Give kind of ost of working life. DO NOT use re		16b. Kind of Business/I	
36 in 72 h	Plete	Elementary/Secondary (0-12) College (1-4 or 5+)	tudent	ured)	School	
d within	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam		Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once	a	Avery Smith			ole Davis	
Should and Marice		19a. Informant's Name/Relationship (Type, Print) Jennell Nickole Davis 113	Address (Street and Number or S. Potomac St	Rural Route Num	nber, City or Town, State smt Apt, [Waynesbord
e, M 1 and 2 Health item 2	ı	2Da. Method of Disposition 20b. Place of Dispos	ition (Name of cemetery,	Date	20c. Location - City or	PA 17268 Town, State
Pages ent of unt: If		1 Burial 2 Cremation 3 Removal from State crematory or oth On—Si		0/2012	Baltimore	e, Md
Baltimore, permit. Pages I ar Department of Hee important: If ite injury or other tr		21. Signature of Funeral Service Licensee	reand Ardra Prof Webst	- 1.		01015
	_	23a Part I. Enter the disease, or complications that baused the death. Do not enter the	00 Wabash Ave			Approximate Interval
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wound of Left Buttock	is mode of dying, oddr do odraide	or roopiidiony dire	oot, onloon, or nour	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transit		events resulting in death) Last Due to (or as a consequence or): d.				
yrician urial -	edical	UNPENDED : AMENDED				
Ox 6876(eath certificate : attending phys for use as the b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	tal death 3 Ectopic pregr	nancy	23d. Date of delivery Month) Day Year
Box 6876 e death certificate the attending phy ed for use as the b	Physician/M	past 12 months? 4 Pregnant at time of death 5 Ot	her (Specify)			
the d	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S 00 9	ā			1 Yes	2 No 3 Prob	eably 4 Unknown
cords, law requir	lete			24a. Was a autop		topsy findings available ompletion of cause of
Reco The law cate has	Completed				med? death?	
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check			
n of Vita ding Physicia After this cer funeral direct		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of I		• —	Residence 6 Other	:
Division of Vital Records, ral or Attending Physician: The law requin ra after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification: To	1 Natural 5 Pending Jul 14, 2012 0542 hrs	1 Yes 2 ✓ No		t by law enforceme	ent
ViSion Attu	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.	28f. Location (S or Town, S	Street and Number or Ru	ral Route Number, City
Ospital hours a nneral I	8	4 Homicide determined (Specify) Local Street		5100 block of	Arbutus Street, Baltin	
표 중 로 및 📆 (Check only 1 L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To the within To the comple	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		Mr -	O.C.M.E.		July 14, 2012	
3		30. Name and address of person who completed cause of death (Item 23a)	AA/ Deltimone Ctool D. "	ND 04:	222	
	ata	31 Date filed (Month, Day Year) 32 Registrar's Signature	W. Baltimore Street, Baltii			
Sta	ate	OLI DELL'ANDIAN, Day, Teat	Kad	0.0	OME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ 9:55AM July 18 Therese Jane Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) Country) 1 - M 2 X F Director 213-54-5892 November 25. 1919 Ohio 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sho 10a. State the Maryland Director Examiner must be notified 1 X Yes 2 ☐ No D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral with 1 items 23a 20016-1934 United States 3706 Fordham Road. N.W. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 0 þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes Give Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates. WW II the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public School <u>Teacher</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental မှ Page 1 and 2 should be in nent of Health and Menta Mary Ann Herlihy traumatic William Felter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 3706 Fordham Road, N.W. Washington, D.C. 20016-1934 Son William H, Bailey, Jr./ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mcematery crematory or other place) torium, Inc. July 20, 2012 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 1 Burial 2 X Cremation 3 Removal from State Crematori<u>um</u>, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund Service Licensee M00335 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury the attending physician and ched for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ğ or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 ☐ Yes 2 🗓 No after death. Director: After this certificate I 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier Thomas Mas Jesson July 19, 2012 D50534

30+1

Registrar

DHMH 17 Rev 06-2011

M.D. 1313 Dolley Madison Boulevard #302, McLean, Virginia 22101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Thomas M. Masterson,

31. Date filed (Month, Day, Year)

JUL 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 2 1 8 1

			1 - State Registrar		C	ertificate of L	Death		Reg. No.	16	23104
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death						ith		3. Time of Death
Medica		al	Bong Jo Bae					July		012	2:40 рм
	Examiner		4a. Facility Name (if not institution, g. Subwrban			· ·	r Location of Death Bethesda		4c. County of		omery
	Funeral		Social Security Number 6.		e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1 9	9. Birthplac	e (State or Foreign
	Director		217-72-3632	1 X M 2 □ F	78 Yrs	Months Days	Hours Min.	(Month, Day		Country)	<i>ipan</i>
	nd how at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location	<u> </u>	10/07	71755		Inside City Limits
	faryla Ba-f s tified	ecto	Maryland Mont	gomery	,		lver Spri	ing			1 ☐ Yes 2 X No
	the N or 20	١	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		
	h with nust t	Funeral Director	10921 Inwoo	d Avenue,	#127		20902			u.s.A	•
	r deat r iter iner r	/ Fu	11. Marital Status1 ☐ Never Married 2 X Married	12. Was Decedent E Armed Forces? 1 Yes 2 X	Ever in U.S. 1	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American I White, etc.	ndian,
21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 Widowed 4 Divorced	1 ☐ Yes 2 【☐ If Yes, Give Year or Dates.	No	1 Tes 2 No	Specify:		Specify:		sian
5-0	hour natur dical	Completed	15. Decedent's (Specify only highest	Education		cedent's Usual Occup			16b. Kind of Busin	ness/Indust	try
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Ba	permit Depar Impor any in		21. Signature of Funeral Service Lice	Smith	MO1564	22. Name and Address 1800 New H					
Physician Medical			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	the death. Do not e	enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Inte	proximate erval Between
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		ner	Sequentially list conditions, if any, leading to immediate	D	consequence oi).	mul Accu	ien.				
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events c.								
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8760	cate b physi s the t	Medical		d .							
68	certifi nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		B			23d. Date of	of delivery	
Вох	s that the death cert igned by the attendir be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1	y	Month Day			Year		
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S, P.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burial-transi	ed by	Tarrii. Other significant conditions	contributing to death of	ut not resulting in th	e underlying cause giv	rentin Farti.		pacco use contribu es 2 □ No 3		
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0 0	Attending Physician: The law refeath. ector: After this certificate has by the funeral director, page 2	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day		/ work		28d. Describe ho	w injury occurred		
isio	l or Attendatter deatt Director: I in by the	ertifi	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju		m, street, factory, office 28f. Location (Street and Number or Rural Route Number)			ite Number,		
<u>≥</u>	ital or irs aftural Dir iled in			building, etc				City or Town			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check 2 \square Medical Exar	ysician: To the best of r niner: On the basis of ex rse Practitioner: To the	amination and/or inv	estigation, in my opinio	 n. death occurred a 	t the time date an	diplace, and due to	the cause's	and manner stated.
_	Vithin Comp	-	29b. Signature and title of certifier	014	_	29c. License			9d. Date signed (N		
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_			30. Name and address of person who				num Dood	Rothag	la Marco	and o	0814
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	Registra	_	JUL 2 3 201	2 Chara	r's Signature	West					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 05 A Tal 2012 Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday Funeral **X** 1 □ M 2 □ F Hours Min. (Month Day Year) MD 74 217-34-5749 **Director** 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No **Baltimore** Anne Arundel MD 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be U.S.A. items 23a Funeral 21225 316 Snowhill Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify **Black** Specify "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Telephone Company Laborer 12 other t traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F ပ **Beatrice Brooks** Page 1 and 2 should be iment of Health and Menta Jerry Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
316 Snowhill Lane, Baltimore, MD 21225 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trau Marguerite Brooks Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Jul 18, 2012 Mt. Calvary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. months disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ģ Month Day Year Pregnant at time of death the a 9 Unknown P.O. igned by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l autopsy performed' certificate 2 🗌 No 1 TYes Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident 1 Tyes 2 🗌 No Investigation Suicide 6 🗌 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number nd address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Date of Birth (Month, Day, Age (In y **Funeral** Year) 1 M 2 F 217-40-207 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medic al Examiner must be notified at 1 Ves 2 No MORE **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent Armed Forces Was Decedent of Hisp If Yes, specify Cuban, Race American Indian 12. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 20 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LE Ind Elementary/Secondary (0-12) College (1-4or 5+) her's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ၉ nformant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Raral Route Number, City or Town, State, Zip Code) 19a 2/2 to. Μd 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisensee 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or responsible, or heart failure. List only one cause of ach line. Approxi ate Interval Between Onset and Death ratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 4 Honknown 1 🗌 Yes 2 No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes 2 ER/Outpatient 3∏ DOA 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) è

State Registrar 30. Name and address of person

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #768 Per FH G929 7/23/2012 JH ealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AROL 10°7 BUSCHMA 16:43 M 2012 Medical 4a. Facility Name (if not institution, give street and **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OF MARYLAND MEDICAL UNIVERSIT BAUTIMORE 7. Age (In yrs. last birthch...) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 11/09/1945 **Director** 218-46-3077 1 🗆 M 2 🗶 F 66 Maryland or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director N/A 1 XYes 2 No MD <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1125 Battery Ave 21230 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0 à 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be file ment of Health and Mental I tant: If item 27 is marked o မ Francis Thomas Doris Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1125 Battery Ave. Baltimore, MD 21230 Gerard T. Buschmann (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 07-14-12 Brooklyn Park. MD Holy Cross Cemetery Signature of Fuperal Service Licensee 22. Name and Address of Facility MOO-732 McCully-Polyniak Funeral Home 130 F. Fort Ave. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a cor attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed2 Yes 2 No 2 No 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner: 1 Yes Hospital 2 No 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 1518281062 who completed cause of death (Item 23a) (Type, Print) S. GREENE STREET, BALTIMORE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HENRY WILLIAM BOESSEL, SR. Physician/ July 20, 2012 2:50 P М Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Brooklyn Park Examiner 4c. County of Death Guardian Angel Assisted Living Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 216-20-4082 **Director** 1 M 2 □ F 85 Sept 19, 1926 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Evanciner must be neithfied == 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1638 Belt Street 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) B & O Railroad **Pipefitter** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Giles Boessel Mary Tully 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry William Boessel, Jr. (Son) 1638 Belt Street, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Loudon Park Cemetery 1 A Burial 2 Cremation 3 Removal from State 7/24/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00175 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ asomer resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last ate has been signed by the _ttending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Noknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No Yes 2 1 🗌 Yes Director: After this certification by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 400 Other: ပ္ 1 Tes ALF 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1. Natural 5 Pending 2 Accident
3 Suicide 1 🗆 Yes 2 🗌 No Investigation within 24 hours after des To the Funeral Director completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 7/21/12 Taymory Mili D47683 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller B24 1525 OWINGS MILLS 21117 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

✓ DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20perVERB.G929, 72372012, W.S. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 201^{Yea} PM Marvin Arthur Comer 3:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester 11100 Coastal Hwy. Unit# 1301 Ocean City Social Security Number If Under 1 Year If Under g. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** oct. 7, 1930 Days Hours 1 X M 2 🗌 Months Min. 218 26 8541 81 Pennsylvania **Director** Usual Residence of Decedent or 28a-f shorn 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? r items 23a or ner must be n Funera 123 Montrose Avenue 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 XMarried þ Maryland 21215-0036 Specify: White If Yes, Give Korean Year or Dates. War 1 Yes 2 No Specify. "natural", 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/Operator Construction Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မှ Marvin O. Comer Sara M. Madden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn L. Comer (Wife) 123 Montrose Ave. Baltimore, Maryland 21221 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Gardens Of Faith Cemetery 7/23/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home_P.A. 21. Signature/of Funeral Service Licensee oten Th Maryland 21221 1407 Old Fastern Avenue Es Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ tortic disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 🍝 attending physician for use as the burial Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. Fetal dea 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year the detached g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completed filled in by the funeral director, page 1 Yes 25. Was case referred to medical B 26. Place of Death (Check only one, 2ndexaminer? Other: 2 No 4 ☐ Nursing Home → Hesidence 6 M Other (Specify) Residence Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natura 2 Accident (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ture and title of certifier 2gb 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Skeeles Campbell 15 July 12:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months (Month, Dav. Year) Country 281-12-2118 Director 1 M 2 XF 92 21, 1920 Apr. Ohio Usual Residence of Decedent or 28a-f show notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. tant: If Item 27 is marked other than "natural", or items 23a or 28a-f shoi jury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Rockville 1 Yes 2 XNo Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 14109 Flint Rock Road 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, မှ Hazel Ferne Brown Stanley Thomas Skeeles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14109 Flint Rock Road, Rockville, MD Robert B. Campbell - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place permit. Page Department Important: If any injury or Wooster Cemetery 7-21-2012 4 ☐ Donation 5 ☐ Other (Specify) Wooster, Ohio 21. Signature of uneral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between shock, of heart fails Immediate Cause (Final Onset and Death Physician/ Poorly differentiated carcinoma, pelvic origin disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Directo (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 the attending physician hed for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 1 Yes 2 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be Malnutrition 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial fibrillation After this certificate has autopsy performed? Yes 2 No Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 X No 1 🔲 Yes ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1X Natural 5 Pending 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-15-2012 D 52503

Registrar

DHMH 17 Rev 06-2011

1500 Forest Glen Road, Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shailesh K. Sheth, M. D.

2 3 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ rawford 2012 233 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hopkins HOSPITA Himore If Under **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Hours **Director** 1 M 2 F VEC, Usual Residence of Decedent 23a or 28a-f show 10b. County be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 4.9,A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) dary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number r Rural Route Number. permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trai 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Dongtion 5 Other (Specify) 21. Signat if of Funeral Se once. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sefsis Ph, si_ian Medical resulting in death) Due to (or as a consequence of) Examiner morua Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached t 9 Unknown Division of Vital Records, P.O. s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 🗹 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖪 No ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? Accident Investigation within 24 hours after death To the Funeral Director, Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar 1800 N Orleans St. Baltimore.

(Item 23a) (Type, Print)

ack

cause of death

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4b. City. 4c. County of Death Baltimore 4 Brubar Court Apt 1C 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 03 Year) 36 Days Hours Min. Country) 235-58-5315 Director 76 1 . M 2 F or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 4 Brubar Court Apt 1C 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ۾ Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hyglene. I other than " 12th grade College (1-4 or 5+) State of Maryland Caregiver Be permit. Page 1 and 2 should be filed Daparment of Health and Mantal Hy Important: If Itam 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flora M. Jordan Earl Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Brubar Court Apt 1C, Baltimore, MD 21207 John M. Cunningham-Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Garrison</u> Forest Vet 7/27/2012 Owings Mills, Md 21. Signature of Funeral Service Licenses Marchard Andreas of Facility t 4300 Wabash Ave, Baltimore, Md 21215 23a. Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): sician and burial-transit Examir e Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.
I 24 hours after death.
Funeral Director: After this certificate has bean signad by the attending physician and lettely filled in by the funaral director, page 2 should be detached for use as the burial-transli Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Division of Vital 86 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Medical Examiner: On the basis of examination and/or investigation in the cause (s) and manner as stated. Medical 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the only one) 29b. Signature and title of certifier and address of person who completed ause of death (Item 23a) (Type, Print) Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ *aw*)tord 012 Medical me (if not institution Location of Death **Examiner** 4b. City, Town County of Death Rurnie TIMORE Glen Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 220-58-8259 Director 1 X M 2 □ F 59 November 30,1952 Washington, D.C. 28a-f shov 10a. State ir than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie 1 Yes 2 X No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States 102 North Crain Highway, #869 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than 1 any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4 or 5+) 8 Plumber Plumbing Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Peggy M. Merson Durward E. Crawford, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela L. Mamula/Daughter 1545 Ringe Drive, Severn, Maryland 21144 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 17. Lakemont Memorial (Gardens 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Davidsonville, Maryland 21. Signature of Funeral Service Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Expores M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bronchogenic disease or condition days Medical resulting in death) Due to (or as a con uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 1 Inpatient 2 ER/Outpatient 3 DOA |₽ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Watural 5 Pending injury work? 1 ☐ Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) (Item 23a) (Type, Print) 30 31. Date filed (Month, Day, Year) State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20<u>12</u> Lillian Readmond Conrad 13 \mathbf{P}^{M} 9:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours (Month, Day, Year) 577-24-4357 **Director** 1 M 2 X F 88 October 7, 1923 Washington, D.C. Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Yes 2 X No. 10e. Street and Number ō r items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Main Street # 133 20878 United States death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give "natural", or iterr edical Examiner r 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F James Spencer Readmond Anna C. McVery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health gitem 27 i Victoria C. LeStrange / Daughter 20030 Lake Park Drive, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of Montgometry, crematory or other place)
Montgomery
Crematorium, Inc. permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State July 18, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Robert A. Pumphrey Funeral Home, Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician) Acute Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Anasarca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hypovolemic Shock and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Status Post Aortic Valve Replacement Box 68760 e as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 mont 1 Yes 2 X No Pregnant at time of death Month Day Year ed by the a 9 🗌 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, Completed 1 Yes 2 No 3 Probably 4 Number peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page Yes 2 X No 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? After 28d. Describe how injury occurred 1 X Natural 5 Pending injury n 24 hours after death.

The Funeral Director: All pletely filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

101

To the I within 2 To the I complex

Registrar

only one

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anglin, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 JUL 2 3 2012 32. Registrar's Signature

A. par

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

July 16, 2012

29c. License number

D55148

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ July 18, 2012 Viola Cassis 4:50 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 102 Kenilworth Park Drive Apt 1B Towson **Funeral** Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Min 212-20-0268 85 **Director** 1 🗆 M 2 🗶 F 3/31/1927 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No Marvland | Baltimore Towson 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21204 U.S.A. Kenilworth Park Drive apt 1B Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc 'natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joanna Eksarhow Anthony Kataculos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Kataculos / Brother Nicholas 102 Kenilworth Park Drive apt 1B Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orth. Cemetery 7/21/2012 |Woodlawn, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MUNTHS Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 proofths?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes Should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: As completely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one 29b. Signature and t tle of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2 3 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ₽2/012 JUTY 21, Patricia Ann Davidson 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Middle River Baltimore 1213 Fuselage Avenue If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign (Month, Day, Year) Days Hours 73 226 50 3644 **Director** 1 🗆 M 2 🔀 4/19/1939 Virginia Usual Residence of Dece vorts 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 No Maryland | Baltimore Middle River 10e. Street and Numbe ō 10f. Zip Code Citizen of What Country?
United States 23a Funeral 21220 1213 Fuselage Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ural", or iten Examiner 14. Race - American Indian, Black, White, etc. Armed Forces ρ 1 Never Married 2 Married 2 XNo 1 Yes 2 If Yes, Give within 72 hours after Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural" Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry oe filed wn. ⁴af Hygjene. ⁴ar than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the General Motors Corp. and Mental Hygien ris marked other th Assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment. Important: If item 27 is marked any injury or and Audy Lovell Lola Salyer traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Fuselage Avenue Middle River Maryland 21220 Bobby Davidson Jr. (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem Gardens 7/25/2012 Baltimore County Md. ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 complications (ha) caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Enter the disease, or or heart failure. List o Interval Between Onset and Death 6 Months hock Immediate Cause (Final Physician Small Cell Carcinoma of Lung disease or condition Medical resulting in death) **Examiner** 6 months Chronic Lymphocytic Leukemia Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Examir burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year ed by the a detached i been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Diabetes Mellitus Type II Physician: The law page 2 s autopsy performed? death? Chronic Obstructive Pulmonary Disease this certificate 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🙀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending work after death.

Director: Af
d in by the fu Accident 1 Tes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hin 24 hours aft the Funeral Di mpletely filled in Medical 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one)

State Registrar

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29b. Sign**ature** and title of certif

31. Date filed (Month, Day, Year)

Danielle L. Brown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

107 Beacon Road Baltimore Md 21220

wan MD

2. Registrar's Signature

29c. License number

00069794

29d. Date signed (Month, Day, Year) 23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decede Physician/ 2013 :300 M Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Baltimpre Melvin Ave. Apt. A atorsville Birthplace (State or Foreign Country 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** 1 M 2 G F Hours OCT 4: Months 218 44 2632 Director Usual Residence of Decedent show 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location Director Catorsville 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code Funeral 309 Melvin Aue. Apt. A 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) arpenter Be 18. Mother's Name (First, Middle, Maiden Surnan Father's Name (First, Middle, Last) umokins John W. Duvall SR. 19a. Informant's Name/Relationship (Type, Print) City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, llian D Duvall - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Memorial 4 ☐ Donation 5 ☐ Other (Specify) Signatu of Funeral Service P. March FH 270 Fredhilton Rass Bulto. MD 21229 Approximate Interval Between Onset and Death nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line Immediate Cause (Final Physician END STAGE REACK DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DIABELES Sequentially list conditions. Examine cause. Enter Underlying HIGH BLOOD Cause (Disease or linjury DRESSURE P.O. Box 68766 that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant a Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown TOTAL HIP REPLACEMENT Records, To the Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No NA Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending iniury 1 XX Natural Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in any policy. Medical 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number Dec 30542 119/2012 5. 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CON INSTRACT NADA 2W RELLING CRESSERADS SUITE 25 CARDNEVILLE, MARTIAND 21228

State

Registrar

31. Date filed (Month, Day, Year)

arks

32. Registrar's Signature

vΟ

State Registra

29b. Signature and title of certifie

Donna M. Vincenti, MD

ORIGINAL

Assistant Medical Examiner

32. Registrar's Si

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

OCME

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

July 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Elaine Carr Dixon 12:30 a^M .T117v Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlestown Catonsville Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Director 215-12-4453 91 1 M 2X F March 18, Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Lane 21228 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ ☐ Yes 2 Z No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ε. Ethel M. Stewart James Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 313 G. Willrich Circle Forest Hill, Diane D. Krauch MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 7/24/2012 Sykesville, Maryland Signature of Euneral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Slephen ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician Due to (or as a consequence of) Dementia disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exam or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or injury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sirral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

after death. Director: After filled in by within 24 hours a Hospital

State

Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

2 3 2012

29b. Signature and title of certifier

*KusunBinkharat Cent

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burkharat 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🖵 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

7/19/12

29c. License numbe

R165717

12-05446
Daniel Delcher

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

aniel Delcher		State of Maryland / Departn 1-For State Certific Registrar	cate of Death	nygierie _{Reg.}	No. 201	2 2320
Physicia	in/	Decedent's Name (First, Middle,Last)	1 1	2. Date of Death Month	av Year	3. Time of Death 0058 hrs
/ledical Exami		Daniel Garrett D 4a. Facility Name (if not institution, give street and number)	Delcher 4b. City, Town, or Location of De	July 20, 201 ath	4c. County of Death	
		St. Agnes Hospital	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b		Ars. 8. Date of Birth of Ain. July 12	MM/DD/YYYY) 9. Birth Foreign 2, 1956 Cou	
ħ	Ì	Usual Residence of Decedent 10a State 10b. County 10c. City, Tow	vn or Location			10d. Inside City Limits
d how any		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	atonsville			1 Yes 2 X No
daryland 28a-f show i at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	ry?
ith the N 23a or 2	_	55 Wade Avenue	21228		U.S.A.	
ath with	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - Americ White, etc.	an Indian, Black,
fter des		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Wh	ite
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a	 Decedent's Usual Occupation (Give kind during most of working life, DO NOT use) 		6b. Kind of Business/Ir	dustry
336 thin 72 l than "1 edical F	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Unemployed		N/A	
5-00 ed with lygiene other	S	17. Father's Name (First, Middle, Last)	18.Mother's Na	me (First, Middle, Ma		
21215-0036 Juid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at once.	Be	Milton Boyd Delcher	Gen 19b. Mailing Address (Street and Number of	e Carolee	German	7in Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	٤	19a. Informant's Name/Relationship (Type, Print) Elizabeth Ann Radebaugh Sister	200 Cork Lane #104			
e, N 1 and 2 Health Titem 7	ł	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery, natory or other place)	Date :	20c. Location - City or 1	own, State
Pages sent of nut: If or othe		4 Donation 5 Other Specify: Cari	roll Cremation, Inc 7	/23/12	Hampstead	Maryland
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingary or other traumante event, the Mediany or other traumante.	ļ	21. Signature of Funeral Service Licensee Classes M Genkins	22. Name and Address of Facility ELINE FUNERAL HOM	11824 Re	isterstown	Road 21136
Physician	-	23a. Part f. Enter the disease, or complications that caused the death. Do	DDITE TOTIETE			Approximate Interval Between Onset and
ivedical. Examiner	ı	faiture. List only one cause on each line. Immediate Cause (Final disease a. Acute Bronchopn	eumonia			Death
Lammor		or condition resulting in death) Due to (or as a consequence of):				
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
V 3	ami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	241			
executed an and al-transit	a E	dd	,27,per me,g930 8-29	9-12 sm		
60, tre be executed hysician and e burial - transit	fedical Examiner			, 12 UM	23d. Date of delivery	
3876 rtificat ling phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	2 Fetal death 3 Ectopic pre-	gnancy		ay Year
lox 6876 eath certificate e attending phy for use as the l	Physician/N	4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
O. Be at the d by the trached		Part II. Other significant conditions contributing to death but not result			acco use contribute to t	
S, P.C nires that signed d be deta	q pa	Hypertensive Atherosclerotic Car	diovacsular Disease	1 Yes		ably 4 ✓ Unknown opsy findings available
cord: aw requas been as peen 2 shoul	Completed by	and Schizophrenia		autopsy perform	prior to co	ompletion of cause of
Rec The l ficate h	Con		26.Place of Death (Che	1 ✓ Yes 2	No 1 ✔ Ye	2 No
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER	- IOther -		esidence 6 Other	
ing Phy After th funeral	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28	b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sion Mttendi death. cctor:	catio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	28f Location (Str	reet and Number or Rui	al Route Number City
Divisior pital or Attenc ours after death teral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	, Jami, Street, Jactory, Office building, etc.	or Town, Sta		4,1,04,01,01,01,01,01,01,01,01,01,01,01,01,01,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the buris.	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medical Examiner: On the basis of examination and/or	death occurred at the time, date and place, or investigation, in my opinion, death occurre	and due to the cause ed at the time, date ar	(s) and manner as state and place, and due to the	d. cause(s)
To To COUT	Med	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		Mm L	O.C.M.E.		July 20, 2012	
P		30. Name and address of person who completed cause of death (Item 28) Russell Alexander MD. Assistant Medical Examine		timore. MD 212	23	
s	tate	De De Stad (14 11 D. V. 1) 122 Pasiatrada Cianatura	5. 555 T. Ballinolo Ollock, Ball			
Regis			all -	00h	1E	
DHMH 17 Rev 1/2	2001	, , ,	DRIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Duke 10:06 PM 3013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clan MD **Baltimore** NUVSI 14 more 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 17, 1930 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🙀 M 2 🗆 F Days Hours Min. Country) MD Director 82 249-46-9219 Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No **Baltimore Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21217 1600 Mt. Royal Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc ō 1 Never Married 2 Married ð 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Specify: "natural" Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susie Dukes **Dick Dukes** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21217 1010 West Baltimore Street, Sarah Epps 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Jul 20, 2012 Lansdowne, Maryland Mt. Zion Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CANCRI nknown Medical resulting in death) Due to (or as a consequence of Examiner quantially list our ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death detached g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Pid tobacco use contribute to the cause of death? Completed by Disease dialysis gebenga ₩ Yes Division of Vital Records, 2 🗌 No 3 Probably page 2 should renal disease - cancer 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 0

Registrar
DHMH 17 Rev 7/2009

State

Nor th

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pelmei

2 3 2012

31. Date filed (Month,

er, CRN1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ju^Mry 17, 2012 4:40 A M С. DiPaolo Jerome Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Timonium Baltimore Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days 215-09-2294 **Director** 1 🛛 M 2 🗆 F Yrs 95 Jan. 13, 1917 Maryland Usual Residence of Deceden 28a-f show hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Towson Md. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Court 21286 Southerly #303 12. Was Decedent Ever in U.S. Armed Forces?1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify Completed 3 X Widowed 4 Divorced WWII White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event the." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) V.P. & Director of Sales National Brewing Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillian Daddario Vincent DiPaolo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monkton, Maryland 21111 800 Maplehurst Dr. Kristine R. Kelly/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd. 7/21/12 | Timonium, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or conshock, or heart failure. List only polications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final Onset and Death ebiliTu Ph sician/ disease or condition Medical resulting in death) mary cancer site Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying executed Cause (Disease or injury that initiated events the burial-tra resulting in death) Last Physician/Medical that the death certificate be signed by the attending p d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIPAOLO autopsy perform 2 🗌 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) JEROME 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes within 24 hours after deatn.

To the Funeral Director; A completely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 17-17-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD JUSTINE PREIS, CRNP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 7.8 per fh g930 8-3-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monty Medical Examiner 4b. City, Town, or Location of De GIL CREST OLUNI Security Number If Under 1 Year If Under 24 Hrs last birthday) 8. Date of Birth (Month, Day, 1942 9. Birthplace (State or Foreign **Funeral** 393-44-0399 Months 1**X** M 2□F Director Dec. 2, 1945 TN28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🔀 Yes 2 🗆 No MD Howard Columbia 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5495 Cedar Lane #305 21044 USA than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates. 1966–68 Specify: 3 Widowed 4x Divorced B1ack Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Minority Business Elementary/Secondary (0-12) College (1-4 or 5+) Business Development is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ James Frank Estes Sr. Frances Delores Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Estes - Daughter 1906 Shorewood Blvd #261 Shorewood, WI 53211 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Metropolitan Crematory 7/19/12 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 21. Signature of Funeral Service Intenses 5517 Vine St. Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death PROSTATE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner PANCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FAILURE BONE MARROW 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 WOther (Specify) Harbells 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? within 24 hours after death. To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15th 2012 072139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 MD 21044 SYED ABBAS CEDAR COLUMBIA LANE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Andrew Fornalik State of Maryland / Department of Health and Mental Hygiene 2012 23204 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3 Time of Death **Medical Examiner** Month 0915 hrs July 16, 2012 Andrew Emil Fornalik 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3407 Grayvine Lane Mitchellville Prince George's 5. Social Security Number **Funeral** 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 1X M 2 F 59 Yrs 153-46-5104 8/3/1952 Country) N.J Usual Residence of Decedent 103 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No t. Pages I and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene frant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must handled. MD Prince Georges Mitchellville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 Grayvine Lane 20721 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. 2 3 Widowed 4 Divorced If Yes, Give Year 1974-1980 1 Yes 2 X No specify: Specify: White \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ traumatic event, the Medical 21215-0036 4 Computer Sciences Computer Programing 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Andrew Fornalik Sophie Leciston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₩. Janet Fornalik Sister Wood St, Garfield, NJ 07026 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 X Removal from State Qonation 5 Other Specify. 7-21-12 St. Michael's Cemetery South Hackensack, NJ 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA 22310 irt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician /Medical Part I. Enter the disease, or complication sillure. List only one cause on each line Approximate Interval Between Onset and Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed and Physician/Medical UNPENDED attending physician or use as the burial -AMENDED The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? 至 ۵. Diabetes mellitus, Congestive heart failure 1 Yes 2 ✔ No 3 Probably 4 Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autonsv certificate has performed death? Yes 2 V No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: d in by the f Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined within 24 hours To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical one) 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 17, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Pay Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2012 Physician/ 6:15 P M Friedlander July 17 Fay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 🗓 F Director 579-56-3189 Yrs. November 27, 1919 Germany 92 Usual Residence of Decedent works 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at rector 28a-f 1 Yes 2 X No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ms 23a or must be i Funeral 20814 United States 5807 Ipswich Road "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Completed White Year or Dates er than "natur , the Medical B 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker is marked other aumatic event, the Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Chefredakteur Fritz Walter Frieda Gehorene Bohny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9500 E. Pennsylvania Ave., Ste. 11, Upper Marlboro, Maryland 20772 27 permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. John E. Stringer/ POA/CPA July 19, 2012 20b. Place of Disposition (Name of cemeter, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Crematorium, Inc. Robert and Apumphrey Tuneral Home/Bethesda- Chevy Chase, Inc. 21. Signature of Funeral Service Lipensee How Hann 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can e on e ch line. nterval Between HHyrosclarotic Onset and Death ADDIOVASCULAR DISEASE Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sacusofielly list our differ a Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform 1 ☐ Yes 2 ☐ No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 흔 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending 24 hours after death.

E Funeral Director: A pletely filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signatu ted cause of death (Item 23a) (Type, Print) Raffel, DOFACP, 5413 West Cedar Lane, Ste. 203C, Bethesda, Maryland 20814 100 Elliott

Registrar
DHMH 17 Rev 06-2011

State

2 3 20°

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 GRA 00:45 AM Medical **Examiner** Town, or Location of Death 4c. County of Death Samaritan Baltimore 103 If Under 24 Hrs. age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 237-50-1822 Director 1 **X** M 2 □ F 78 Yrs. 7-22show 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified Baltimore 28a-f 1 ¥ Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles 19a. Informant's Name/Relationship (Type, Print) Gray 20a. Method o Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Bultimore, Md permit. ature of Funeral Service Licens GREENE FUNERAL SCUS Road. Enter the disease, or co olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List o Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): signed by the attending physician and defected for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vunknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 5 \square Pending iniun 1 Natural 1 Yes Accident Investigation 2 No 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of

State Registrar

DHMH 17 Rev 06-2011

of person who completed cause of death (Item 23a) (Type, Print)

lamling

31. Date filed (Month, Day,

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			For State Registrar	State of IVI	aryland / Depa <i>Cer</i>	tificate of L		иептаг пу	gierie Reg. No.	012	221	2 0 -
	Physicia	m/	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of De	eath
-	Medic	cal	Paul Thomas 4a. Facility Name (if not institution, give s	Geck:	le	4. 01. 7		1-17	2/	2012	1525	М
	\ Examir	ier	SINCY HOSPILEI OF		ive	Bal	r Location of Death HMORE		4c. Coul	nty of Death		
	Funeral Director			ТМОПЕ	e (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02/06)	71944	9. Birthp Count Mary I	place (State or F try) and	oreign
	and show	ē	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	ation				1	0d. Inside City I	Limits
	Mary 28a-f	irec	Penna. York		Airville						1 Yes 2	₩ No
	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 458 E. Posey Road			10f. Zip Code	7302		-	of What Coun d State	•	
	r death ir items		11. Marital Status 1 □ Never Married 2 🏧 Married	12. Was Decedent E Armed Forces?	If	/as Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - America Black, White, e		
900	ırs afte ıral", c I Exam	ed p	3 Widowed 4 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates.	Vietnam 1	☐ Yes 2 🙀 No	Specify:		Spec	eify: Whi	.te	
21215-0036	72 hou n "natu fedica	Completed by	15. Decedent's Edu (Specify only highest grad	le completed)	(Give k	ent's Usual Occup ind of work done of NOT use retired)	during most of work	ing	16b. Kind of	f Business Inc	lustry	
	Hygiene. other thar ent, the N		Elementary/Seconday (0-12)	College (1-4 or 5	0+)	stems Ana	_		S	inai H	ospital	,
Maryland	12 should be filed lith and Mental Hy 27 is marked oth r traumatic event	To Be	17. Father's Name (First, Middle, Last) Francis Xai	ver Geo	kle		18. Mother's Nam Mar				enberge:	r
0	12 shoulth and 27 is rr		19a. Informant's Name/Relationship (Type Christina Granruth	, ,			and Number or Rura Place Be					
	ge 1 and 2 s t of Health If item 27 or other tra		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispos			Date		on - City or To		
Baltimore,	Emen tmen tant: jury		4 Donation 5 Other (Specify)		Holly Hil	l Mem Gai	rdens 7/2				ounty M	
Ba	permit Depar Impor any in		21. Sign Ture of Euneral Service License			Name and Addres	ss of Facility Eastern A				Home P2 d 21221	A
	Ph_sician/ Medical Examiner		23a. Rart). Enter the disease, or complished, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line	I the death. Do not enter. SHOUL LV a consequence of):			or respiratory ar	rest,		Approximate Interval Betwee Onset and Dea	
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of):					-		
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300	te be exe tysician a he burial-	I— I	resulting in death) Last	d	a consequence of):					\perp		
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of 1 Live Birth 4 Pregnant at	2 Fetal death 3 E	Ectopic pregnance Other (specify)	ру			Date of delive	ery Day Yea	ar
P.O. E	it the d d by the etached	Phys	g ☐ Unknown Part II. Other significant conditions cor	g ∐ Unknown	ut not reculting in the u	adarlying sayso siy	ren in Port I					
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Division of Vital Records,	The law re ate has be page 2 sh	Completed by						24a. Was auto perfo			psy findings ava npletion of caus	
ta	icían: Sertifica ector,	Be	25. Was case referred to medical examiner?	ospital:		26. Pla	ace of Death (Check					
of V	g Phys er this eral dir	e: To	27. Manner of Death	1 Inpatie		28c. Injury	4 ∐ Nursing Ho y at	ome 5 Resident			HOSPICE	
ion	tending death. tor; Aft the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	v, Year) injury								
Divis	ital or At urs after or ral Direct lled in by		4 Homicide determined	building, etc				28f. Location (S City or Tov	vn, State)			
	the Hosp nin 24 hou the Fune ppleted fin	Medical	only one) 3 Certifying Nurse	er: On the basis of ex	my knowledge, death o xamination and/or investi best of my knowledge, d	gation, in my opinic	on, death occurred at	t the time, date a	and place, and o	due to the cau	ise(s) and manne	er stated.
	-		29b. Signature and title of certifier	MIN MO		29c. License	number 5 000		29d. Date sign	ned (Month, D		
	9		30. Name and address of person who co	mpleted cause of de		int)			1-	C1 - C0		
	Stat	te	31. Date filed (Month, Day, Year)	32. Registra			Odlan	WE PIO				

State Registrar parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month <u>12:</u>10a^M 07 18 2012 Lee Gummer 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Chapel Hill Nurse & Rehab Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, O8 O4 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) Year) 1 □ M 2**X**□ F 216-26-7634 77 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Randallstown 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21133 U.S.A. 3710 Elkanah Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) LGWU Elementary/Secondary (0-12) College (1-4or 5+) Garment Union 12th grade na Business Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Nelson Dewey Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2916 Silver Hill Ave, Baltimore, Md 21207 Terrance M. Gummer-Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign turn of Funeral Service License Garrison Forest Vet7/26/2012 Owings Mills, Md of Funeral Service Licensee 22. Name and Address of Facility March F/H West Wabash Ave, Baltimore, Md 21215 4300 23a. Parl 1. Enter the obsease, or complications that caused the shock, or heart failure. List only one cause on each tine. Immediate Cause (Fina. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Crywison Pavs disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 1 Yes 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner that the death certificate be executed

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death

2 should be filed within and Mental Hygiene.

permit. Pages 1 and 2 Department of Health

Important: If it any injury or concourts

3altimore, Maryland 21215-0036

/Medical

MD

Director

Funeral

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Completed

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physician and s the burial-transit attending pl signed by the a has page certificate this funeral din

P.O.

Division or Vital Records,

or Attending

Examiner Physician/Medical Completed by Be ျှ

To the Hospitai State

Medical Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the f

29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

5 Pending investigation

6 Could not be determined

(Month, Day Year)

29c. License number

+ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year)

2012 105

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21802

leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co Box 00 Z, Dell

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sark

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Donald Warner Gates, Sr. 14, 7:20 AM July 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 217-32-4326 74 **Director** 1 XM 2 | F Nov. 13 1937 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified 1 X Yes 2 No VA Accomack Greenbackville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2297 Rudder Court 23356 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces?

1 XYes 2 No Black, White, etc. ō þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify: "natural" White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired Elementary/Secondary (0-12) 12th College (1-4 or 5+) Lab Technician Food & Drug Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Walter Lee Gates Mary F. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Janet Lou Gates/Wife 2297 Rudder Court, Greenbackville, VA 23356 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial XXX Cremation 3 Removal from State 7/19/2012 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Odenton, MD Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Intel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Cardiac Arrest Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last Atherosclerosis Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? Yes 2XXN this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 💆 ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1XXNatural 5 Pending 2 Accident 1 Yes 2 No Investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 📭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 110/2017 D0069351

State Registrar SNOW HILL, MD

21863

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

104 North Bay Street

32. Registrar's Signature

60N9

31. Date filed (Month, Day, Year)

that the death certificate be executed P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician:

3 Baltimore, Maryland 21215-0036

should be filed and Mental H

physician

has

certificate

After

after death Director:

within 24 hours a

To the Funeral C

completely filled

State

Medical

29a. Certifier

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my reliable death.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5 Marshalle Dr. Elkridge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1020 AM +101+haus Medical 4a. Facility Name (Anot institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death care C mwell? Ithmore If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Mary land Director iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Baltimore **Baltimore** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1804 Snow Meadow Lane Unit 302 21209 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or ģ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify White Specify: Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DQ NOT use retired)
GEOLOGIST permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (3-4 or 5+) Penman & Brown, Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary McLaughin Harry E. Holthaus, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1804 Snow Meadow Lane Unit 302 Baltimore MD James Holthaus/Brother 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp. 7/24/2012 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ²²Teonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ disease or condition resulting in death) urars Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 D 2 No g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) RN MS CRNT 8710 Emge Rd. Baltimore, MD 21234 31. Date filed (Month, Day, Year)

JUL 2 3 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11 per fh g929 7-24-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Month 20/2 Philip 05269M J. Hebrank Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Dorchester General Cambridge HOSDITA Dorches 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F 214-14-8357 Months Days Hours Min (Month, Day, Ye 89 Director 06-21-1923 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Direct Maryland Dorchester Cambridge 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 1704 Brannocks Neck Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 2 No WWII Black, White, etc. TENever Married 2 Married Completed by 1X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes. Give Specify 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) School System School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felix Hebrank Elizabeth Agnes Olszewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne H. Morgan - Daughter 11 Stonewood Court Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 07-23-2012 Baltimore, Maryland 21. Signal re of paperal S whe Licensee 5305 Harford Road 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, Maryland 2121 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. fr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nocadisease or condition resulting in death) dia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 \(\text{Other (specify)} \) Day Year Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed? certificate filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 7 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of gert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5058 M Leona Patty Holloway 012 Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 100 200 U 1 honor 1 house e-n . Social Security Number 2 1 8 – 8 2 – 5 5 7 2 If Under 1 Year I If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours Director 1 🗆 M 2🔀 F 51 08/22/1960 Maryland filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or Items 23a or 28a-1 show 10a, State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director N/A Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 3309 Gwynns Falls Pkwy U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2X Married Maryland 21215-0036 Black 1 Yes 2 No Specify: Specify: Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Homemaker 12th Grade Be 17. Father's Name (First, Middle, Last)
Leroy Smith ¹⁸ Mother's Name *(First, Middle, Maiden Surname)* Earlene Burton Mental I Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3309 Gwynns Falls Pkwy, Baltimore, MD 21216 Ted Holloway (Husband) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State unk Date õ unkemetery, crematory or other place) = 0 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Joseph Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD 21217 elleans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 216 Ste Medical Due to (or as a consuluence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): 24 hours after death.

24 hours after death.

5 Funerel Director. After this certificate has been signed by the ettending physician and iletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day ☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nalmuntin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Pontre demuelinization 24a. Was an autopsy performed? Yes 2 1 Hy Derthasiu 1 Yes 2 40 25. Was ca referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ke and title of certifie 29b. Signat 29d. Date signed (Month, Day, Year) U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per INF C947 1/13/2014 III State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death JUTU Physician/ Alice Mae Wise Henry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sivai Haspital of BaHimore Faltimore N/A **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 1 M 2 XF 249-52-2869 SC 84 Sep 7, 1927 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4113 West Rogers Avenue 21215 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3XXWidowed 4 ☐ Divorced Specify: Completed Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) **Beautician Beauty Shop** Department of Health and Mental Hygi Important: If item 27 is marked other eny injury or other traumatic event, is once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Eddie Henry** Hattie Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21207 Hattie Smith Shannon 2828 Arlene Circle, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/24/2012|Timonium, Md. Dulaney Valley 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sundrome heparorenal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a considuence of The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ned by the atten detached for u in the past 12 months? Month Year Day] Yes 2 □ No 9 Unknown Records, P.O. ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KICHEY disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? auticoagulation 24a. Was an autopsy performed Yes 2 24 hours after death.

4 Funerel Director: After this certificate I letely filled in by the funeral director, pag 1 🗌 Yes 2 🗆 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a Certifier within 24 hou To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, RES -000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Zdol W. Belucdere Ave., Kristine T. YUMUL MD 31. Date filed (Month, Day, Year) State 2 3 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per inf g930 8-10-12 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year John Edward Holt 0528 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Somerset <u>Crisfield</u> Edward McCready Mem Hospital Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Days Min 220-64-4153 **Director** 1 X M 2 | F 57 02-12-1955 Maryland Usual Residence of Decedent show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD 1 Yes 2 No Somerset Crisfield 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a27645 Fairmount Rd. 21871 U.S.A. items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 Yes, 1 Yes 2 No "natural", Specify: 3 Widowed 4 W DIVorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other transmone. ၉ pe 1 Boyd Thomas Holt, Sr. Ella Irene Robinson 19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boyd Thomas Holt 1584 Marco Dr. Pasadena, ĴΓ. Md 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Emanual Baust Cem. 07-19-2012 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee Name and Address of Facility
McCully-Polyniak Funeral Home M00 - 732P.A. Ulm 204 Mountain Rd. Pasadena. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASCU D disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months? Day 1 Yes 2 No 9 Unknown detached g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ျ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year)))(ME 42012) 15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syder . CM 100 Ecarroll St. P.s 31. Date filed (Month, Day, Year) 32 Registrar's Signature State arke Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:00 A M **Physician** Patricia Ann Hurst JUly 17, 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1165 Punjab Drive Essex Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F 59 216-62-3205 June 12, Virginia Director Usual Residence of Decedent 10d Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examiner must be notified at 1 ☐ Yes 2 X No Essex Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with t leath and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 2 21221 1165 Punjab Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 6—12/1973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11, Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Alarm Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Virginia Schmuff Golden Haves ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7039 Concord Road, Pikesville, Maryland 21208 Health item 27 i Raymond Hayes (Brother) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2012 Cedar Hill Cemetery Ju₁v Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Folyniak Funeral Home, P.A. Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 MOO175 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MYOCARD INFARCTION Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tra physician attending | led by the a

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				
CHRONIC O	ns contributing to death but not resulting in the under BSTLuCi) VE PuCHODA	RY DISEASE	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
PERIPHER	ZAL VASCULAR D	DISCASE	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No			
25. Was case referred to medical		26. Place of Death (Check only one)				
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investiga	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □Yes 2 □No	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my knowledge, death oc :xaminer: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place tigation, in my opinion, death occ	be, and due to the cause(s) and manner as stated. Eurred at the time, date and place, and due to the cause(s)			
29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day,				
Doct	MA	DCC ZOC	Tuly 17th 2012			

State

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PHILADELPHIA PD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS H. ODIE

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certif	icate of	Death		Re	eg. No.	Uli	4 2321
Physicia	ın/	1. Decedent's Name (First, Midd	•					Date of Deat Month	Day Yea		3. Time of Death 0006 hrs
Madical Exami		Michael Lee 4a. Facility Name (if not institution	Hamilton,	Sr		b. City, Town, o	or Location of De	July 10, 20	4c. County of	of Death	0000 1115
		Sinai Hospital	M, give street and numbe	,		Baltimore	E E COMMON ON DO			N/A	
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs, last	birthday)	If Under 1 Ye			th (MM/DD/YYYY	9. Birth	place (State or
Director		214-88-9638	1XM 2 F	5	O Yrs.	Months Day	ys Hours I	Min. 06/23	3/1962	Coun	ht∭aryland
		Usual Residence of Decedent				J.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		100/20	771702		
w any		10a. State 10b. County		10c. City, To	wn or Locati	on				- 1	10d. Inside City Limits 1 Yes 2 No
yland -f sho	į	Maryland 10e. Street and Number	N/A	Balt:	imore	40f Zin Onda		T 10	Og. Citizen of Wh		
or 28a	Director					10f. Zip Code	1.5	''			y r
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mantal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	alD	3803 Lewin Ave	nue 12. Was Deceder	nt Ever in U.S.	13. Wa	212 Decedent of H		(Specify Yes or No	U.S.		an Indian, Black,
eath v	Funeral	1 Never Married 2 M	Armed Forces			es, specify Cuba			White		
after d	D. F.	3 Widowed 4 Div	vorced If Yes, Give Year	Z NO	1	Yes 2 N	o specify:		Specify:	Whi	ite
nours a	8	15. Decedent's Education (Spe				's Usual Occupa st of working life			16b. Kind of Bu	siness/Inc	dustry
36 In 72 In 72 I	Completed	Elementary/Secondary (0-12)	College (1-4 o	1					Danles A	1 d	oton Inc
with grene	E	17. Father's Name (First, Middle			LOIKTI	ft Oper		ame (First, Middle, N	L		gton, Inc.
215 e filec tal Hy ked of	4		•					ne Glaes			
213 ould b	2	Ronald Hamil 19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stre	eet and Number	or Rural Route Num	ber, City or Tow	n, State, Z	Zip Code)
MD 21215-0036 at 2 should be filed within 7 thin and Mantal Hygiene. In 27 is marked other than aumatic event, the Medical		Timothy Jone 20a. Method of Disposition	s (Brothe	r)	1312	Saloni	ica P1a	ace Bel	Air, M	d 21	1014
s l an of Hea		20a. Method of Disposition 1 Burial 2 Cremation		state crer	natory or oth	er place)					
imo Page nent c		4 Donation 5 Other S	Specify:	At1				/14/2012	Glen	Burr	nie,MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee MOO-7	32	22. N M (ame and Addres	ss of Facility -Polvn:	iak Fune	eral Ho	me I	P.A.
Physician	\dashv	23a Part I. Enter the disease, or	r complications that cause	ed the death. Do	not enter th	0 4 Mo1	ıntain such as cardia	Rd. Pas	sadena, est, shock, or hea	Md art	21122 Approximate Interval
//Medical		failure. List only one cause	e on each line.								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Morphine Due to (or as a con	Intoxical insequence of):	cation					-	
		Sequentially list conditions,	b								
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):							
ı ii	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):							
ecuted and rans			d	22- 27	20 - 6		-020	0 14 12	CM	-	
760, toate be executed physician and the burial - transit	Medical	▼ UNPENDED	$oldsymbol{x}$ AMENDED $oldsymbol{\#}1$,			,per me	.,g930	8-14-12			
8760, tificate be ng physical as the bundar in the bundar	ξ	IF FEMALE: 23b. Was decedent pregnant in the	the 23c. If yes, outc	ome of pregnan		al death 3	Ectopic pre	gnancy	23d. Date of Month	Da	y Year
ox 6	sician	past 12 months?	- Lucasium	at time of death		ner (Specify)					
Bc he dea	Phy	Part II. Other significant condit	9 Unknown	ath but not rocu	ting in the u	ndorlying cours	given in Part I	23e Did to	bacco use contri	bute to th	e cause of death?
Division of Vital Records, P.O. Box 68 tall or attending Physician: The law requires that the death certif its after death. al Director: After this certificate has been signed by the attending led it by the funeral director, page 2 should be detached for use as	by	Fattii, Other Significant Condi-	dona Continuating to dea	atti but not resu	iting in the a	nderrying cause	giveri ii r aici.				bly 4 🗸 Unknown
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of \	-1	27. Manner of Death	28a. Date of Ir (Month, Day		b. Time of Ir	njury 28c. Inj	ury at Work?		now injury occurre		
for: A	ațio.		nding stigation fd 7-1	ے ا	d 00:0	6 am 1	Yes 2 X No	unknown			
Nis o At affer d D rect	Certification:	3 Suicide 6 X Cou	uld not be 28e. Place of	Injury - At home	e, farm, stree	t, factory, office	building, etc.	28f. Location (S	street and Number tate) 3803 I	ewis	Route Number, City
Spital Dours of Filled	Se	4 Homicide		roup Ho	5 T 1 2 T 1			Baltim	roe.MD.		
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled it by the funeral director, page 2 should be detached for use as	ical	(Check only	Physician: To the best of aminer:On the basis of ex								
To To Com	Medical	29b. Signature and title of certific	and manner state	d.		29c. Licen	nse number		29d. Date signe	ed (Monti	h, Day, Year)
	-	In God King	Shall mix			0.0	.M.E.		July 10, 20	12	
		30. Name and address of person	n who completed cause o	f death (Item 23	a)				I		
		Pamela E. Southall, M		dical Exami	ner 900	W. Baltimo	re Street, B	altimore, MD 2	1223		
		31. Date filed (Month, Day, Year)	33 Regist	trar's Signature	1	, ,					
Regist		JUL 23	CUIL Bersu	7	mark						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Honth Th 2012 9:10a. M Audrey Johnson Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Baltimore Examiner 4c. County of Death Joseph Richey Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours 58 213-64-5697 Director 1 ☐ M 2 🐼 F 04 29 54 MD Usual Residence of Decedent or 28e-f ehov 10a, State 10b. County ar then "neturel", or items 23e or 28e-f eho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Merylend Director MD NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3027 West 21215 U.S.A. Garrison Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married ٤ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Black Specify: 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 9th grade (0-12) College (1-4 or 5+) Self Employed Seamstress permit. Pege 1 and 2 should be filed Department of Health end Mental Hy, Importent: If item 27 is merked other eny Injury or other treumetrations. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Ward Mary Avery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6575 Overheart Lane, Columbia, Md 21045 Rhonda Johnson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/23/2012 Baltimore, Md Signature of Juneral Service License 22. Name and Address of Eacility March F/H West Kala 4300 Wabash Ave Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Approximate Interval Betw IF STORY Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ate has been signed by the ettending physicien and pege 2 should be deteched for use as the buriel-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co woute to the cause of death? þ 2 V No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Tohnson Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy perfor certificate To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to ma æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 □No 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27, Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 6 Could be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certification 29d. Date signed (Month. 0

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Priscilla Flavia James 16 2012 9:49a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1604 East 30th Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day, Year)
0 7 11 38 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 🛣 F 212-36-6142 Director 74 MD Usual Residence of Decedent other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? by Funeral 1604 East 30th Street 21218 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: If Yes Give 3X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Private Agency for (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Emotional Disturbed 12th grade Residential Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Randall John Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1911 North Fulton Ave, Baltimore, ິກິdື 21217 Carole Curtis-Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 7/24/2012 Owings Mills, Md of Funeral Service License 21. Sign ttura 22. Name and Address of Eacility
March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.

Immediate Cause (Final disease or condition resulting in death)

a. Dise to for se a consequence of: 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death Ph_sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it ary, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Hospital or Attending Physician: The law requires that the death in the past 12 months? Day Pregnant at time of death 2 🗆 No been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Yes 2 1 Yes 25. Was case referred to widical Be 26. Place of Death (Check only one) examiner? Hospita Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specific 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completed filled in by the funeral Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. CALVERLY ST. SHAWN 3333 BALTIMORE MD 31. Date filed (Month, Day, Year)

JUL 2 3 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of	Marylan	d / Depa	ırtment	of He	ealth a	and Me	ntal Hy	giene	Э			
			State Registrar				Cer	tificate	of De	eath			Reg. N	· 20	1) '	2322
н	Physicia	n/	Decedent's Name (F	First, Middle, L								Date of Dea Month	D	^{ay} 2012	ear		ne of Death
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	Funeral		5. Social Security Numl		Sex 7.	Age (In yrs. la	ast birthday)	If Under 1		mins If Under 2		Date of Birt	th	9	rrol		ate or Foreign
	Director		218-42-7027	7	1 🔀 M 2 🗆 F	65		Months [Days	Hours	Min.	(Month, Day uly 22	y, Year)	946	Count	ylaı	nd
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ē,	1 and of Hear item		20a. Method of Dispos	ition		20b. P	Place of Disposemetery, crem	sition (Name	of		Dat			Location - Ci			•
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Baltimore,	permit. Page 1 a Department of P Important: If it any injury or of		21. Signature of Funera	al Service Lice	* V) A (L	nKs	- 22	Name and A	Address	of Facility	11	824 Re		ersto	wn I	Road	136
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?		th 2 ☐ Feta ntattime of c	aldeath 3	Ectopic pre Other (spec						23d. Date of Month		ery Day	Year
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of	ng Ph ter th neral	ë	27. Manner of Death	5 Pending	28a. Date of (Month,	injury <i>Day, Year</i>)	28b. Time of injury	28c	. Injury a work?	at	280	l. Describe h	ow inju	iry occurred			
on	tendil eath. or: Ai the fu	iica	2 Accident	Investigat	ion			М		es 2 🗆	No						
Division of Vital Records,	I or Attendii after death. Director: A	Certificate:	4 Homicide	determine	28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	et, factory, o	ffice		281	. Location (S City or Tow		nd Number c e)	r Rural	Route N	lumber,
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	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2	Medical Exa	miner: On the basis urse Practioner: To	of examination	n and/or invest	igation, in my	opinion,	, death oc	curred at the	e time, date a	and plac	e, and due to	the cau	use(s) and	d manner stated
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Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

5 203

Baltimore

21209

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith AV

32. Registrar's Signature

NSRAJAPAKSE MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Keefer Ruth Sayler 2012 2:55 P 18 Medical July 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll Westminster Emeritus Senior Living If Under 1 Social Security Numbe 7. Age (In vrs. last birthday Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 1 🗆 M 2 🔀 F Months Days Hours Min Maryland 1918 **Director** 217-09-9207 Feb. Usual Residence of Decedent 28a-f show 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 5002 Durham Rd. E. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ō 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: "natural" 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) sewing factory 12 seamstress other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Emma May Geiselman permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic. Isaac W. Sayler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21044 5002 Durham Rd. E. Charles Ecker/ nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/22/2012 nr. Union Bridge, MD Mt. Union Cemetery 21. Signature of Dineral Service Li Hartzler Funeral Home, P.A. attanne Ε. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or imjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) ending physician use as the burial Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter for u in the past 12 months? Month Day Year Pregnant at time of death No ped the P.O. signed by the 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director. / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) State 3 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1122AM 18 J'612 Lipscomb Donald Delano Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Deitmore Maso. Innurc 8. Date of Birth (Month, Day, Year)
04 07 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 75 Hours Min 235-60-4526 1 **X**M 2 □ F **Director** WV 37 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Yes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'Is marked other than "natural", or items 23a or 'Is marked other than "natural", or items 23a or """" or items the Medical Examiner must be r Funeral U.S.A. 21207 3420 Yataruba Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 X Married 21215-0036 Black 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 🗌 Widowed 4 🗌 Dîvorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation | 16b. Kind of Business/Industry | Baltimore City (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4 or 5+) 5yrs+ Public Schools Principal Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Fannie L. Tipton James Lipscomb injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 Yataruba Drive, Baltimore, Md 21207 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trait Shirley A. Lipscomb-Wife 20b. Place of Disposition (Name of Date 20c Location - City or Town State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland National 7/25/2012 Laurel, Md unatural of Funeral Service Licensee March Fr Hof West 21215 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. Approximate Interval Between Orget and Death mediate Cause (Final bde Ph sician/ Nal disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): 68760 % resulting in death) Last Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year signed by the at d be detached for Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ev. the me tastation Division of Vital Records, oax coma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ad Staa 24a. Was an page 2 s has autopsy the pertes perform certificate 2 No Yes 2 X/N funeral director, 25. Was cas referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 □ No 1 Manatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 🗌 Natural injury 5 Pending 710 PM within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 🗐 No 2 Accident 28f. Location Street and Number or Rural Route Number, City or Town, State) Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Heer-outside of home 3490 Gataruna Souther Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check **Certifying Nurse Practitioner To the best of my knowledge death fort the division 29b. Signatore and title of certifier 8 &X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Danel

53

Snow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 16 2012 LYLES KEY 4:16 AM THELMA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospita] Frederick Frederick 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) Director 217–30–6521 Usual Residence of Deceder 1 □ M 2 🕱 F 78 Yrs Nov. 22, 1933 Maryland show 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 28a-f s 1 Yes 2 No Frederick Libertytown Maryland or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Examiner must 9528 Keys Chapel Rd. 21762 U.S.A. or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", If Yes, Give 3 XWidowed 4 ☐ Divorced Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee. College (1-4 or 5+) Elementary/Secondary (0-12) 12 nursing assistant hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Kev Martha Dorsev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Lois Cimino/ niece Hagerstown, MD 21742 1242 Potomac Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 7/20/2012 Resthaven Mem. Gard. Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal e of Egneral Service Licen 22. Name and Address of Facility Hartzler Funeral Home, P.A. atharine 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interva Between Onsel and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final hemispheric cerebral inforct Ph_sician/ disease or condition resulting in death) Medical Examiner inknown Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con equence of To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown Acute Revel Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has 1 ☐ Yes 2 ☐ No Yes 2 N funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔼 No Other: ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 Yes 2 No 5 Pending Accident Suicide Investigation after death filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 172977 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Marius

31. Date filed (Month, Day,

NO

MD

82. Registrar's Signature

400 W.

7th St

Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:05 PM Physician/ Ε. Medical Herta Lewis 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel <u>Baltimore-Washington Medical Center</u> Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min, (Month, Day, Year) Months Hours 258-54-6211 Director 1 🗆 M 2 🖾 F 1919 93 May 21, Germany Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Evaminar must be netified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7900 Benesch Cir. Apt 800 U.S.A. 21060 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 5-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 College (1-4 or 5+)
N/A Elementary/Secondary (0-12) 12 Hecht Company Supervisor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilhelm Anton 19a. Informant's Name/Relationship (Type, Print) Personal) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
570 Bellerive Drive Annapolis, Maryland 21403 Todd K. Parker(Representative) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) D7/17/2012 Atlantic Cremation Glen Burnie, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 M00-732 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death 00 ancer Physician astal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause Filer Underlying

Cause (Disease or injury) Due to (or as a consequence of) **To the Funeral Director:** After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 menths?
1 Yes 2 No 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed. 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) Type, Print) ospita KIVE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 7:30 PM **Physician** July 20, 2012 Miller David George /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Essex 606 Carvel Grove Road If Under 1 Year If Under 24 Hrs. If Under 1 Year Hours Min. 8. Date of Birth (Month, Day, Year) 12/17/1947 Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral X**X M 2□ F 64 Kentucky Director 216 54 3010 Usuel Residence of Decedent 10d. Inside City Limits illed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Exeminar natatibe notified at 1 ☐ Yes 2 📉 No Baltimore 21221 Md Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 606 Carvel Grove Road 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Ses 2 ☐ No If Yes, Give Year or Dates: 1968–70 11 Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Baltimore, Maryland 21215-0036 White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Metal Fabricator Sheet Metal Worker 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) jes 1 and 2 should be fill of Health and Mental Hy if item 27 is marked oth Be Bonnie Garrison Givens George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Gary W. Miller (brother) 606 Carvel Grove Road Essex Maryland 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory INC 723/2012 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Si nature of Funeral Service License 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dis shock or heart failu Immediat Pause (Final disease or condition resulting in death) 2 years **Physician** 217 /Medical Due to (or as a consequence of) **Examiner** Tange Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (e. as a consequence of) Examiner certificate be executed physicien and the burial-transit Due to (or as a consequence of) Physician/Medical as attending IF FEMALE: 950 23d Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) P.O. 1 signed by the a 9 Uaknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has page 1 ☐ Yes 2 ☐ No 2×21No 1 Yes 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Statemen 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1/SNatural 1 ☐ Yes 2 ☐ No To the Hospitel or Attendition 24 hours after death.
To the Funerel Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 138762 07-21-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharen J. McCornack MO = caltimore Md. 21229 Rd -Suite 18 Frederick 11 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MY COST Morris charlie 7 2012 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) 5/17/1935 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days 212-32-6938 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 ☐ No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 21212 DRIVE Cooperative 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Solves 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel Elementary/Secondary (0-12) College (1-4 or 5+) 12 SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilsby AVENUE. Md. 21218 SISTER 3952 BALTO Nunn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 7-27-12 22. Name and Address of Facility Vaughn GREENE Fineras Sexs 21. Signature of Funeral Service Licensee York Road. Balto, MUISSS 4905 York Road. Bulto, replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Quete respiratory
Due to (or as a consequence): hours or as a consequence of): Nows Sequentially list conditions, if any, leading to humodrate cause. Enter Underlying Cause (Disease or injury hours that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

ian/Medical

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Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important; or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once.

use as the burial-transit attending physician

e Hospital

11595

Division of Vital Records, P.O. Box 68760,

hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of c	death 5 Uther	(specify)							
ted by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyir	ng cause given in Part I.	23e. Did tobacco us 1 ☐ Yes 2	se contribute to the cause of death? No 3 Probably 4 Unknown					
Complet	history of lu	ng cancer			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
9	25. Was case referred to medical		26. Place of Death (Check only one)								
D B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4 - Nursing I	Home 5 Residence 6	Other (Specify)					
	27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2 No	28d. Describe how injury	coccurred					
Certification	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci		ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,					
dical (ysician: To the best of my kno niner: On the basis of examina and manner stated.				and manner as stated. I place, and due to the cause(s)					

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

29b. Sign

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MDIPHD

32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

2	3	2	2	8

		1	State Registrar		Cei	rtificate of D	Death		Reg. No.	
Ī	Physicia Medic		1. Decedent's Name (First, Middle, Las	"Miller.				2. Date of Dea Month July 16		3. Time of Death 4:25 A M
٠	Examin		4a. Facility Name (if not institution, give Genesis Health Ca	street and number)		4b. City, Town, or Waldorf	Location of Death		4c. County of Dea	ath
	Funeral Director		243-46-4320	ex 7. Age (<i>In yr</i> s. <i>I</i> a	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct. 1	9. B (, Year) 9, 1933 No	irthplace (State or Foreign ountry) orth Carolina
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County NC Duplin		, Town or Lo	ocation				10d. Inside City Limits 1 ☒ Yes 2 ☐ No
	with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 405 S. Gum Stree		- Daw	10f. Zip Code 28398	3		10g. Citizen of What C	Country?
000	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene. The shalth and Mentel Hygiene. The marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 24 or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏝 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
7-617	hin 72 hou ne. than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 1 2		(Give life. E	edent's Usual Occupi kind of work done of DO NOT use retired) rance Age	turing most of work	ing	16b. Kind of Busines Insurance	
Z DUB	be filed wit ental Hygie ked other c event, tt	To Be C	17. Father's Name (First, Middle, Last) Bryant Miller	Σ	Ilisu	Tance Age	18. Mother's Nam			
Mary	12 should lith and Me 27 is marl r traumati		19a. Informant's Name/Relationship (7 Arlena Miller –	• • • • • • • • • • • • • • • • • • • •					r, City or Town, State, 2 Warsaw, N	
more,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other plac	7-21	Date -2012	20c. Location - City of Pink Hill,	NC
Dalillinor	permit. F Departm Importa any inju		21. Signatury of Funeral Service (10en			2. Name and Addres	ss of Facility	Metropol	litan Funen ndria, VA	al Service
eric ,	Physician/		23a. Part 1. Enter the disease, or composition of the composition of t	plications that caused the death one cause on each line.	n. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory are	n Cer.	Approximate Interval Between Onset and Death
أميا	Medical Examiner		resulting in death)	a		renal				
	ted d insit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ	ience of):	ue to	thriv	ξυ.		
2	ificate be executed g physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a consequent	uence of):					
. BOX 66/60	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fete 4 Pregnant at time of c	al death 3	☐ Ectopic pregnand	су		23d. Date of c Month	delivery Day Year
S, 7.	uires that th signed by ld be detac		Part II. Other significant conditions of Hypertension	contributing to death but not res	ulting in the		ven in Parthellow	.0.		to the cause of death? Probably 4 Unknown
Records,	The law requate has been bage 2 shou	Completed by	Anaemia, De	pression, Hy	pper 1	ripi de	nía_	24a. Was auto perfo 1 Yes	psy prior to	autopsy findings available o completion of cause of es 2 No
VITal	sician: certifica irector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	EB/Outpatio	Oth	er:		dence 6 ☐ Other (Sp.	ecify)
N TO UC	nding Phy ath. : After this e funeral d	icate: To	27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Injur	y at		now injury occurred	Soliyy
DIVISION	al or Atter s after des al Director ed in by the	Certificate:	3 Suicide 6 Could not l 4 Homicide determined	pe 28e Place of Injuny - At ho		treet, factory, office		28f. Location (City or Tov	Street and Number or F vn, State)	Rural Route Number,
	e Hospit 124 hour e Funera eleted fille	Medical	(Check 2 Medical Exam	ysician: To the best of my know niner: On the basis of examination rse Practioner: To the best of my	n and/or inve	estigation, in my opini	on, death occurred a	at the time, date a	and place, and due to th	e cause(s) and manner stated.
1	To the within to the comp	2	29b. Signature and title of certifier	from.		29c, Licens			29d. Date signed (Mo.	
	58		30. Name and address of person who	completed dause of death (Item	23a) (Type)	PrintionBl	ud, Ster	3, G1/e	n Burnu	mp, 21061
ľ	Sta Begistr		31. Date filed W.Achth, Day, Year)	32, Registrar's Signa	ture	4.1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 357 Elbert Alphonsus Martin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square Hospital Baltimore Rosedal Year If Under 24 Hrs. Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year) 05-31-1929 213-26-5710 Months Days Hours Min. **Director** 1 X M 2 - F 83 Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 5214 McFaul Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) General Foreman Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Leo Martin Ella Mae Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Brian Martin - Son 3832 Dakota Road Hampstead, MD 21074 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 07-21-2012 Timonium, Maryland 4 Donation 5 Other (Specify) ti A Fineral Servi 22. Name and Address of Facility Sign Licensee 5305 Harford Road Baltimore, Maryland 21214 Leonard J. Ruck, Inc. the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or peart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death shock Immediate Cayse (Final disease or dition resulting in death) Ph_sician/ Severe Medical Due to (or as a consequence of): Examiner infection urinary Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year isigned by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Director: After this certificate 2 No 1 Yes To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗗 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hat DOO 6328 7-18-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUEER DR Balto ind 21237 DJahanmir 9000 Masoud 31. Date filed (Month, Day, Year 32. Registrar Signature State 2012 Registrar

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Division of Vital Records, as after death. S after death.	in by th	Certificate: To	3 Suicide 4 Homicide	6 Could r determi	:nad 28e. Pla	ice of Injury ilding, etc.	/ - At ho (Specify)	me, farm, str	eet, facto	ry, office			28f. Location City or To			er or Ru	ral Route Num	ıber,
Hospital	letely filler	Medical	(Check 2	Medical E	Physician: To the xaminer: On the li	basis of exa	mination	and/or inves	stigation, in	n my opinio	on, death o	occurred a	t the time, date	and pla	ce, and du	e to the	cause(s) and m	anner stated.
To the	E OS		29b. Signature and		Th	^	1	20		c. License		72	,		Date signe	ed (Month	n, Day, Year)	/ 7
5			30. Name and addr			ause of dea	ath (Item	23a) (Type,	Print)	<u>' </u>	01	1 /			,) '		2/0	3/2/
	Stat	е_	31. Date filed (Mont	th, Day, Year)	BCB 32	. Registrar	's Signat		AK		, 516		vien	134	RU		-60	101
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 18^{bay} 2012 9:05 AM LaVere Masser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Walkersville 5 Monocacy Court If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days (Month, Day, Year) May 2, 1942 1 🛛 M 2 🗆 F Min Yrs. Director 213-40-4536 70 Maryland Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. or 28a-f shove notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Walkersville Maryland Frederick 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 21793 U.S.A. 5 Monocacy Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates.1 964-70 er than "natura, the Medical E 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha church minister 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Marquarite Isabella Fisher Guy Leonard Masser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trait Walkersville, MD 21793 5 Monocacy Ct. Sue A. Masser/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Olivet Cemetery 7/21/2012 Frederick, MD 4 □ Donation 5 🗷 Other (Specify) entembrent any inj ty e of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home, P.A. Woodsboro, MD 21798 404 S. Main St. 23a. Part 1. Enter the disease, or complications that subset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ month disease or condition Medical resulting in death) Due to (or as 7 consequence of): Bladder Cancer **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as autopsy page performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) Hospital 2 12 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 / Natural 5 Pending 124 hours after death.

e Funeral Director: A pleted filled in by the fu after death Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar Kanan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson Dr

32. Registrar's Signature

no mas

31. Date filed (Month,

July

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MONTGO MERY 335 P M JULY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days (Month, Day, Year) Hours 217-26-2448 **Director** 83 1 | M 2 | X F Yrs Jan. 8, 1929 Maryland ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "al Hygiene.
ad other than "natural", or items 23 event. the Medical Examiner must 6650 Allview Drive 21046 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Grade 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ည Edward Eckart Viola Lough and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 6650 Allview Drive Columbia, Maryland 21046 Stephen Montgomery / son or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Emmanuel Cemetery 7/20/2012 Laurel, Maryland Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 21. Signature of Funeral Service Licensee 20707 M00770 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ STAGE DEMENTIA END Monea Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and -trans that initiated events resulting in death) Last ng physician ar Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE; yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL FAIWRE 1 Yes 2 No 3 Probably Onknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 1 Yes 2 No the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 No 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053150 JULY 15 M 2012 Spepte MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 SANTIAGORA

Registrar

SHAKUN MALA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	of Marylan		artment of H		Mental Hy	giene	O 1 0	00000		
			State Registrar			Cer	tificate of E	Death		Reg. No.	1 2	23233		
	Physicia		1. Decedent's Name (First, Middle Glenn	,	her				2. Date of De Month July	Dav	Year 2012	3. Time of Death 7:30 A M		
- 184	Medic Examin		4a. Facility Name (if not institution	, give street and num	nber)		4b. City, Town, or	Location of Dea		4c. County				
			The Residence		belt		Lanham	1		Pri	ince	George's		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir						
	Director		579-30-6460 Usual Residence of Decedent	1 X M 2 □ F	86	Yrs.			Jan 24	, 1926	₩a	shington DC		
	and show	힏	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits		
	Maryl 28a-f otifie	Director	MD Anne	Arundel	I	Laurel						1 ☐ Yes 🏋 🛱 No		
	h the		10e. Street and Number		,		10f. Zip Code			10g. Citizen of What Country?				
	th wit	Funeral	3394 Wye Mills				2072		2 17 17 11	U.S.A.				
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	b	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	100	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Blac	e - Ameri ck, White, · Whi						
2-0	hour hatu dical	olet		nt's Education est grade completed)		16a. Deced	ent's Usual Occupa	ation	a drina	16b. Kind of B				
21	nin 72 ne. han " e Mer	Completed	Elementary/Secondary (0-12)	College (1		life. D	kind of work done d O NOT use retired)	runng most of w	orking					
121	d with tygier ther t	Be C	17. Father's Name (First, Middle, I	4 y∈	ears	Ana	lyst			NS				
Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "traumatic event, the Med	To E	Edward Maher	_ast)					ame <i>(First, Middl</i> e, a Steinha		е)			
Σ	ould he marl		19a. Informant's Name/Relations	hip (Type, Print)		19h Mailin	g Address (Street a				State Zin	Code		
	d 2 shalth a		Robert E. Mahen	c / son		1	Wye Mil					·		
ore,	of Heal fitem ? r other		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date	20c. Location				
<u>i</u>	Page ment o ant: If ury or		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (5		State		lel Crema	1	/18/2012	Odent	on, l	Maryland		
20a. Method of Disposition 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Euperal Service Licensee MOO770 3394 WYE Method of Disposition 1 Removal from State 20b. Place of Disposition of Ceremetery, crematory or other Ceremeters, crematory or other Cer							Name and Address Onaldson 13 Talbo	s of Facility Funera tt Avenı	l Home, F ie Laure	A. A. Marv	land	20707		
			23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final	complications that conly one cause on ea	caused the deat							Approximate Interval Between Onset and Death		
	Physician Medical		disease or condition resulting in death)		brovasc or as a consequ		ccident				-	Acute		
	Examiner				,									
	= =	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):								
	ecuted and -trans	xan	Cause (Disease or injury that initiated events	C. Dun to	or as a consequ	topoo of:								
	ate be executed physician and the burial-transit	dical E	resulting in death) Last	Due to (or as a consequ	terice oi).								
760	cate to physical care to cate	ledic		d	· · · · · · · · · · · · · · · · · · ·									
	ie death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🔲 Live	nant at time of c	al death 3 🗌	Ectopic pregnanc Other (specify)	у			te of deliv	ery Day Year		
, P.O.	law requires that the death nas been signed by the atte e 2 should be detached for	l by Pł	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.				he cause of death?		
rds	requir	etec							-					
eco	has has je 2	Completed by	Renal Insuffi						24a. Was autor perfo	rmed?	prior to co death?	psy findings available impletion of cause of		
<u>=</u>	sician: The certificate l' rector, pagi		Hyper Cholest 25. Was case referred to medical	terolemia			26 Pla	ace of Death (Ch	1 Yes	2 X No	1 🗌 Yes	2 X No		
Vita	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes ※※※ No	Hospital:	Inpatient 2	ER/Outpatien	Otho	AP"	Home 5 A Resid	tence 6 🛛 Oth	er (Specifi	Assisted		
0	fter The	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi	28a. Date (Mont		28b. Time of injury	28c. Injury work	at		ow injury occurr		<u> Living</u>		
Division	al or Atte s after de il Directo ed in by ti		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	of Injury - At ho		et, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rura	l Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	(Check 2 Medical E	Physician: To the becaminer: On the bas	is of examinatior	n and/or invest	igation, in my opinio	n, death occurred	d at the time, date a	nd place, and due	e to the ca	use(s) and manner stated.		
_	Vithi To th	-	29b. Signature and title of certifier				29c. License			29d. Date signe				
	, !		1.ew	4 cm			D24	4997		July 1	7, 20)12		
	30x		30. Name and address of person		,	, , , , ,		102 -	1 15	1	205	.7		
1	Stat	e.	Dr. Luis Casas 31. Date filed (Month, Day, Year)	22. R	egistrar's Signat	ture	ve Suite	TO3 Li	urel, Ma	ryrand	2070	J /		
1	Registra		.111 232	012 Feet	in B.	par								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ 4:10 a M July 19, Nottingham Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) September 9,1939 Days Hours 216-36-6008 72 Maryland Director 1 M 2 X F Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location Director Dundalk Md. Baltimore 1 ☐ Yes 2X No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 7795 Penninsula Expressway Apt 304 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 Tes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanislaus Lewatowski Helen Drejka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Brook Farm Court, Perry Hall, Md. 21128 Linda Rodgers Sister Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of July 23, cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Sacred Heart of Mary Cem. 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Connelly Funeral Home of Dundalk, 7110 Sollers Point Road, Dundalk, 21222 MO1176 23a Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LIVER CANCER resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be execute ed by the attending physician and detached for use as the burlal-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 Unknown After this certificate has been signed by I funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 X No Be 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE မ 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one! 29b. Signature and title 29d. Date sig/led (Mon/h, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Ye.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:30 A M Carlos Robert Plumley July 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Nursing Home Denton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1**X**XM 2 □ F Months Days Hours (Month, Day, Director 229-24-3249 87 16 West Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2x No MD Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 Wood Lane 21629 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

XX Yes 2

If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 2 No 3altimore, Maryland 21215-0036 1 Yes XX No Specify: Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. and: If item 27 is marked other than "natural", ury or other traumatic event, the Medical Exaury or other traumatic event, the Medical Exa Specify: White 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Mechanic Auto Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lonnie Andrew Plumley Lottie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy L. Hall/Daughter Wood Lane, Denton, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 7/19/2012 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Inter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ 1 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner erosche Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of betes The law requires that the death certificate be executed ng physician and as the burial-transit sit illow that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav by the detached 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag-1 ☐ Yes 2 ☐ No 25. Was case referred to medical the Hospital or Attending Physician; Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 14 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 005325 0010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's Agnature

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Physician/ Medical Examiner Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director PANCHOLT, BANSTLAL Baltimore, Maryland 21215-0036 Physician Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Please	Type or Print in Black			_	•).
1 - For State Registrar	State of Maryland / D	epartment of Certificate of		i Mental Hy	Reg. No. 201	2 23236
1. Decedent's Name (First, Middle, Last	t)			2. Date of De	ath Day _Year	3. Time of Death
Bansilal Pancho		1		JULY	19 20	12 /3.0PM
4a. Facility Name (if not institution, give			or Location of De	ath	4c. County of De	
Doctors Community 5. Social Security Number 6. Se			nham If Under 24 H	rs. 8. Date of Bir	Prince G	eorge's
220-11-4243	X м 2 □ F 93 Y	Months Days	Hours Mi			ountry)
Usual Residence of Decedent				April 5	5, 1919 I	ndia
10a. State 10b. County Maryland Prince G	eorge s	or Location Lanham				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
10e. Street and Number		10f. Zip Code			10g. Citizen of What C	Country?
9300 Copernicus D		2	0706		United S	tates
11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of If Yes, specify Cub 	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
3 X Widowed 4 □ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates.	1 🗆 Yes 2 🗶 N	Specify:		Specify:	ian Indian
15. Decedent's Ed (Specify only highest grad	de completed) ((Decedent's Usual Occu Give kind of work done	during most of w	rorking	16b. Kind of Business	
Elementary/Secondary (0-12)	College (1-4 or 5+)	fe. DO NOT use retired Carpente:			Textile	Mill
17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle,	Maiden Surname)	
Vadilal Bhogilal 19a. Informant's Name/Relationship (Typ			Manib			known
Kishor Pancholi /	10011				r, City or Town, State, Z , Maryland	
20a. Method of Disposition	20b. Place of D	Disposition (Name of		Date	20c. Location - City o	
1 ☐ Burial 2 💢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	ricinoval irom State	crematory or other pla ndel Crema	ce) Ju	1y 22, 2012	Odenton,	
21. Signature of Funeral Service License	200	22. Name and Addr Donaldson	ess of Facility 1 Funera	1 Home &	Crematory,	P.A.
23a. Part 1 Enter the disease, or comp	lications that caused the death. Do not	t enter the mode of dyi	IPOIIS K	oad Odent ac or respiratory ari	ton, Maryla rest,	Approximate
shock or heart failure. List only on Immediate Cause (Final	e cause on each line.	66	. 11 .		+	Interval Between Onset and Death
disease or condition resulting in death)	a. Due to (or as a consequence of)	ar fibr		n arr	67	
Sequentially list conditions,	. Myocard		faretw	· · ·		
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a a consequence of)					
that initiated events resulting in death) Last	Due to (or as a consequence of)	:				
	d					
IF FEMALE:	3c. If yes, outcome of pregnancy			- 1		
23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal death	3 Ectopic pregnar 5 Other (specify)	су		23d. Date of de Month	elivery Day Year
9 Unknown	9 🗆 Unknown					
Part II. Other significant conditions con		the underlying cause g	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
peritonit	is cir			_ 1 🗆 '	Yes 2□No 3□I	Probably 4 Dunknown
				24a. Was autor		utopsy findings available completion of cause of
				perfo	rmed? death?	es 2 No
25. Was case referred to medical examiner?			ace of Death (Ch			
T Li res 2 Li No	lospital:		er: 4 🗆 Nursing	Home 5 Resid	lence 6 🗆 Other (Spe	cify)
27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Tim inju	ury wor	(?	28d. Describe h	ow injury occurred	
2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm		Yes 2 No	29f Lagation /S	itreet and Number or Ri	und Davida Musekan
4 Homicide determined	building, etc. (Specify)	, stroot, lastory, office		City or Tow		irai noute Number,
(Check 2 ☐ Medical Examin	cian: To the best of my knowledge, de er: On the basis of examination and/or in Practitioner: To the best of my knowle	nvestigation, in my opin	on, death occurred	d at the time, date a	nd place, and due to the	cause(s) and manner stated.
29b. Signature and title of certifier	0 01	29c. Licens	e number		29d. Date signed (Mont	h, Day, Year)
Yasa Z	er than	D6	4818		07	7-19-2012
30. Name and address of person who co	mpleted cause of death (Item 23a) (Type LIACET 890	pe, Print)	LAICE DI	enus C	linter A/ M	7-19-2012 11/20735
31. Date filed (Month, Day, Year)	62. Registrar's Signature	1 OTO DE	INCA FIV	0,00	LINION I	رورامم ري
AAF & 6 CAIY	serva B. D.	arker				

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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, 2012 July 4:40 A M Shirley Broome Purdy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac 8604 Wild Olive Drive Birthplace (State or Foreign Country) er 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Hours 125-20-6199 Director 1 □ M 2 🛣 F 86 Yrs March 18, 1926 New York show 10d, Inside City Limits 10c. City, Town or Location 10b. County 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Potomac Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20854 8604 Wild Olive Drive United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Publications Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Edwin Broome Mildred Rawls 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 19505 Bodmer Avenue, Poolesville, Maryland 20837 William E. Purdy / Son Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Montgomery
Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State July 19, 2012 Bethesda, Maryland 4 Donation 5 Other (Specify) 21. Sign of A See 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland, 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Months Immediate Cause (Final **Physician** Lung Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Dies to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Other (specify) the s 9 Unknown been signed by the should be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform Yes 2 No after death.

Director: After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🔀 No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accider
3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifi July 16, 2012 D44157 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Seven Locks Road, Suite 111, Rockville, MD 20854 M.D. Berger Lawrence 32. Registras Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Ting Sang Quan 2°0°12 1922 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months (Month, Day, Year) **Director** 216-27-6774 1 X M 2 □ F 77 Yrs. April 15, 1935 China Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 🗙 Yes 2 🗆 No Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 118 Monroe Street, Apt. #1208 20850 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Host 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kwan Yum Duan Lai Yee Jang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lai Man Kan - Spouse 118 Monroe Street, #1208, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parklawn Mem. Park 07/23/2012 | Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lipense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M01024 <u>11800 New Hampshire Ave., Silver Spring, MD 20904</u> 23a. Part 1. Enter the disease o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between one cause on each line. Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition resulting in death) week Medical Due to (or as a consequence of): Examiner Pneumonia 1 Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Examine Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 4 Pregnant rate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Failure, Acidosis, Coagulopathy, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Thrombocytopenia, Metastatic Colon Cancer 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 X N filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🂢 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

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completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

BUAN, TING

Eric Joon-Shik Park, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 2 3 2012

D0060117

July 19. 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 2 per doc 8930 8-6-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7 120 WE 2 Vear 621 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 3142 GRACEFIELD ROAD, #406 SILVER SPRING Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 132-16-4418 1 - M 2 - F Months Country NY 86 05/03/1926 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD SILVER SPRING 28a-f MONTGOMERI 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 0 ms 23a or must be r 10g. Citizen of What Country? Funeral 20304 USA 3142 GRACEFIELD RUAD, #406 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ö ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ADOLPH BARONDES ANNA MOSMAN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a SIEGFRIED ROWE / HUSBAND 3142 GRACEFIELD ROAD, #406, SILVER SPRING, MD 20904 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 ☐ Other (Specify) COLUMBIA MEMORIAL PARK 07/20/2012 CLARKSVILLE, MD re of Puneral S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or com. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ ATHER OS CLEROTIL CARDID UKSIVLAR DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 5 the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CEREBAM VASCULAR PUTENTE FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed? Yes 2 No To the Hospital or Attending Physician; The certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: 4 Nursing Home 5 12 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural injury 5 Pending Work: 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur title of dertifier 29d. Date signed (Month, Day, Year) D24031 MI 7/19/2012

State Registrar

D

GRALEFIELD RUAD

SILVER SPRING NO 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110

Fegistrar's Signatur

MACHIADO MD

2 3 2012

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Day Effa Lee Roehrle 3:30 A M 2012 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min **Director** 215-32-9859 1 M 2 F 77 1/28/1935 ALUsual Residence of Deceden shov 10a. State 10b. County the Maryland 27 is marked other than "neturel", or items 23e or 28a-f sho traumatic event, the Wedical Evanning must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Mt. Airy 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 6341 Davis Rd. 21771 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Floyd Saxton Myrtle Ethelyn Smith 1 and 2 should by Health end Meitem 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronn W. Roehrle (Husband) 6341 Davis Rd. Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Importent: If ite eny Injury or otl once. 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 7/21/2012 Winfield, MD 21. Signature of Funeral Sep-Name and Address of Facility Trier-Queen Funeral Home and Crematory 12 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of sicien end burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physicien thed for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) signed by the at Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed has been sign 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page this certificate 1 ☐ Yes 2 ☐ No Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Sp. 1 Yes 2 E-1No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funerel Director: After completely filled in by the funer 28d. Describe how injury 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 18, 2012 Physician/ Marianne F. Ruch 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months (Month, Day, Year) 491-34-3311 Director 1 □ M 2 X F Yrs. 79 May 8, 1933 Missouri Usual Residence of De 27 is marked other than "netural", or items 23a or 28a-f show traumatic event, tre Medical Examinar must be notified at 10a, State 10b Count 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 ី No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14801 Pennfield Circle # 208 20906 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married è ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 hand Mental Hyglene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Feager Alice Marty I and 2 should b I Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Maples / Daughter 5807 N. 83rd Place, Scottsdale, Arizona 85250 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Montes of Page 1) permit. Page 1 s
Department of H
Important: If ite
eny injury or ot
once. 20c. Location - City or Town, State 1 🗌 Burial 2 🖔 Cremation 3 🗎 Removal from State July 20, 2012 4 Donation 5 Other (Specify) Bethesda, Maryland Crematorium, 21. Signature of Funeral Septice Licensee Robert A. Fumphrey Funeral Home, Rockville, I 300 West Montgomery Avenue, Rockville, Maryland 20850 1 th Inc. M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day signed by the a Id be detached f P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, Completed is certificate has been si director, page 2 should l 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The this certificate ☐ Yes 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) hours after death, neral Director: After this y filled in by the funeral dii Hospice Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours To the Funeral I Hospital Medical hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855 Debrah Miller, 31. Date filed (Month, Day, Year 32. Registrar's Sign State Registrar

Registrar

State

Emanuel Kokotakis, MD 18109 Prince Philip Drive Olney, Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SOPPM Physician/ SONYA REINHART Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death itospited Pa Ihours a 1 house N/A Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 217-24-0421 1 🗆 M 2 ី F 82 11/28/1929 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE OWINGS MILLS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9248 COUNTESS DRIVE 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married δ 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE 3 Divorced Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4 or 5+) SUPERVISOR ADMINISTRATION Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENRY BENJAMIN BESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH REINHART / HUSBAND 9248 COUNTESS DRIVE, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 07/20/2012 WOODLAWN, MD Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., Moses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. BAN disease or condition Medical resulting in death) Due to (or as consequence of) Examiner hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed rsician and burial-trans that initiated events CENTREAT Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🔯 No 28d. Describe how injury occurred Natural 5 Pending injury 6030AM July 15 2012 within 24 hours after death

To the Funeral Director: A

completely filled in by the f Investigation at home 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ountessor. own phills Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signata 2012 and address of person who completed cause of death (Item 23a) (Type, Print) le v 31. Date filed (Monthy Day, Year) State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Physician/ Lethra Stephens UIU 2 Medical 4b. City, Town, or Location of Death Randallstowp 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Northwest Baltimore Hospital Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 - M 2 1 F Hours Director TAN 31 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State with the Maryland must be notified at **Funeral Director** BAITIMORE 1 ¥ Yes 2 ☐ No 10g. Citizen of What Country? ō 23a items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Examiner Black, White, etc. 9 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Maryland 21215-0036 1 ☐ Yes 2 🖪 No Specify: 3 ₩ Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) AIMS EXAMINET Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ GURNEY 19a. Informant's Name/Relationship (Type, Print) STEVE STEPHENS Baltimore, 20b. Place of Disposition (Name of Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BUTUS MEM 12 23a. Part 1. Enter the disease, o condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DreumoNIA Physician/ aspiration disease or condition Medical resulting in death) Due to (or all a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attheroscleratic cardiovascular the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No death? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Medical Certificate: After t 28d. Describe how injury occurred 5 Pending injury 1 Natural Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D00 63198 21 2012 July 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samarina Ahmad 750 Main Street Reisterstown, MD, 21136 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year 43 PM Shillingford $J_{\rm ulv}^{\rm month}$ 15. Joseph Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Adelphi House Prince George's Adelphi If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) 580-14-4070 Director 1 1 1 M 2 □ F 88 Dominica, W.I. July 24, 1923 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MDAdelphi Prince George's 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20781 USA 8402 Rambler Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Religion/Church Pastor 2 should be filed with h and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peterson Shillingford Ivy Jospeh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Silver Spring, MD 20901 Janice Fraser - Daughter 11317 Cresends Place 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 7 - 29 - 12Christiansted, USVI Kingshill Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Funeral Service Ligen 21. Signature of 5517 Vine Street, Alexandria, VA 22310 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Alzheimers Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Month Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 1 → 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsv performed Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending M Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certif he and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walter F. Spiegel 18 2012 11:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) **Director** 186-14-9576 89 11-7-1922 Germany Usual Residence of Decedent show. Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. It should be 72 so marked other than "natural", or items 23a or 28a-f sho itan; if Item 27 is marked other than "natural", or items 23a or 28a-f sho itury or other traumatic event, ithe Medical Examiner must be notified at jury or other traumatic event, ithe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗌 Yes 2 ឺ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 11621 New Hampshire Avenue United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1943

17 Yes 2 No to
If Yes, Give

Year or Dates. 1946 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Mechanical Engineer Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Julian Spiegel Kaethe Placzek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Spiegel - Son 8820 Shining Oceans Way, Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date ☐ Burial 2 【XCremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 7-21-2012 Falls Church, Virginia Brian Deibler 21. Signature of Funeral Service I 22. Name and Address of Facility Edward Sagel Funeral Direction uan Ker 1091 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Interval Betweer Immediate Cause (Final Opset and Death
5 Days Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Advanced Alzheimers Dementia Years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trar attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTN, Failure to Thrive, Dementia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has filled in by the funeral director, page 2 autopsy performed? Yes 2X N 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 X No ျ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending Accident 1 🗌 Yes 2 L No Investigation within 24 hours after death To the Funeral Director. Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ٌ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 3 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

DHMH 17 Rev 06-2011

Rajan Shyamsundar, MD - 9801 Georgia Avenue, Silver Spring, MD 20902

29c. License number

D53367

29d. Date signed (Month, Day, Year)

7-18-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 0700 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genera 401a Howa Howar If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrsuast birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗵 F Months Days Hours Min. (Month, Day, Year) Country) Director July Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral 4710 23rd Parkway, 20748 USA is marked other than "natural", or iten is marked other than "natural", or iten 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 🖎 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ş 1 X Never Married 2 ☐ Married Maryland 21215-0036 African-If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 not applicable not applicable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Derrick Smiley Evalina Jones or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evalina Jones/ Mother 23rd Parkway. T-2, Temple Hills, MD 20748 Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of h
Important: If ite
any injury or ott July 13 20c. Location - City or Town. State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 2012 Odenton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. Kein M01053 313 Talbott Ave., Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performe completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tyes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 🗍 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

710

31. Date filed (Month, Day, Year)

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ive

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti Medical Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death **Examiner** PS If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** Min 1 M 2 F Hours ື19<u>31</u> Yrs Maryland **Director** 81 June <u>213-30-6225</u> Usual Residence of Decedent 28a-f shov 10b. County ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No New Windsor Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21776 U.S.A. 9701 McKinstry's Mill Rd. items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. ò þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. er than "natural", the Medical Exa Specify. 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) service station 12 owner/operator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Ellen Smith Leonard Schabdach Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a 9701 McKinstry's Mill Rd. New Windsor, MD 21776 June C. Schabdach/ wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Peter's Cemetery ! 7/21/2012 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home, P.A. Marine ai Box 249 New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) ea i Medical Due to (or as a consequence f) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed tran Exar and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician s the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate I 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ည 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending death. 1 Yes 2 No ☐ Accident ☐ Suicide Director: / Investigation 6 Could not be hin 24 hours after de the Funeral Directo mpleted filled in by tl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29c. License number 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor 2 nee 21 Yea 3 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Stuckey, III Mortimer Henry 2:30 A M Ju1y 19 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min Months Director 579-50-5238 1 🛣 M 2 🗆 F 74 May 21, 1938 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2X No Rockville Maryland Montgomery ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4r must b Funeral 15113 Sunflower Court 20853 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, an "natural", or ite Medical Exaπiner Was Decedent Ever III U.S.
Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates. Unknown Black, White, etc. by 1 Never Married 2 X Married 5-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Justice the Budget Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marjorie Peed Henry M. Stuckey, Jr. Department of Health an Important: If item 27 is r. any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15113 Sunflower Ct. Rockville, Maryland 20853 Barbara P. Stuckey - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) July 23, 2012 | Rockville, Maryland Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Sign ture of Fungfal Ser fice to insee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final cardiopulmonary Physician/ arres disease or condition Medical resulting in death) Due to (or a la consequence o Examiner res it a ton Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequen of) em bolism rulmonar burial-tra Due to (or as a consequence of resulting in death) Last prostate Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cancer or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 🗌 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural 5 Pending hours after death. Ineral Director: A 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital within 24 hours a To the Funeral I Medical Confifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the of c 29d. Date signed (Month, Day, Year) 69148 7+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Suite 200, Rockville, Mmm d 20850 Matas, MO 10110 Molecular Maricha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 91 55am Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Valley Nursing & Wellness Center montgomery LOLEVI If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Mir (Month, Day Year) 927 1 M 2 X F **Director** 214-22-1503 84 Maruland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be Funeral 23a 10920 Connecticut Avenue 20895 U.S.A. items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🏋 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. Specify Completed 3 Widowed 4 X Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Museum Desianer Museum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Abraham Stewart Elizabeth (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 East West Highway, #201, Bethesda, Maryland20814 Robert McCarthy - Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory: 07/25/2012 Brentwood, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center a 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Yes ☐ Yes ☐ Unknow detached g Unknown cate has been signed by ; page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has, autopsy performed? Yes 2 No After this certificate 2 (No 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ₺No Hospital: Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death 2 L Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12012

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

2 Tomac

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Jul*u* Doba Shapiro 11:00 am 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) Director 076-76-1213 1 □ M 2 💢 F 100 02/25/1912 Russia or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6121 Montrose Road 20852 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if flem 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 (Unknown) Benthion Shapiro Sarra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15905 Indian Hill Terrace, Derwood, Maryland 20855 Boris Benenson - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Ft. Lincoln Crematory 07/27/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Funeral Service Licensee MO1024 an 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease excomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ rneumonia disease or condition resulting in death) Medical Examiner phagia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed Parkinsons Discape and that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Demention 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Records, P.O. Box 68760 Division of Vital 24 hours after of Funeral Direct 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Hullastory R142291 18/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Hebrew Home Hillary Rosenberg 31. Date filed (Month, Day, Year) State Registrar W DHMH 17 Rev 06-2011 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jul 16, 2012 **Eugene Smith 2240** M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Carroll Hospice - Dove House 8. Date of Birth (Month, Day, Year) **Nov 21, 1937** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 **X** M 2 □ F Md. Director 213-32-3935 74 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 □ No Finksburg Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21048 U.S.A. 3141 Lawndale Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. X Yes 2 No2/10/1955 ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give Specify: 3 Divorced 4 Divorced 7/31/1958 Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Admin. **Employee** 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillie Smith William Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5512 Fernpark Avenue, Baltimore, MD. 21207 Loretta Smith 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Owings Mills, Md. Jul 25, 2012 **Garrison Forest Veterans** 4 ☐ Donation 5 ☐ Other (Specify) Signature of Francisco L Name and Address of Facility

Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Luny disease or condition resulting in death) Cancer Medical Due to (or as a c dequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Lause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Year Pregnant at time of death the g Unknown 9 Unknown P.O. signed by to Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Khown Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has , page perform 1 Yes 2 No certificate Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: Inpatient 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of the funer of the function of the funer of the function of the funer of the funer of the funer of the funer of the function of the function of the funer of the function of the funct 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 015552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$26 Washington Rd. Ste 204 Westminster, md. 21157 M. D. Jaiunt 2 32/ Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:00a M Month Jul 10, 2012 Physician/ **Cecil Mae Stukes-Simmons** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown **Northwest Hospital** Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 SC 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min Oct 20, 1934 Months Days Hours 1 🗆 M 2 🗀 F **77** Director 247-56-6844 show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 28a-f Windsor Mill 1 A Yes 2 No **Baltimore** MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò must be by Funeral U.S.A. 23a 21244 3302 North Rolling Road ed other than "natural", or items event, the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examin ury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Yes. Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Homemaker **Own Home** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ٥ Drucilla Eddy Oscar Brayboy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3302 North Rolling Road, Windsor Mill, MD 21244 19a. Informant's Name/Relationship (Type, Print) 3302 North Rolling Road, **Betty Whitaker** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Jul 17, 2012 Windsor Mill, Md. King Memorial Park 4 Donation 5 Other (Specify) 21. Si Natura Tuneral Service L ne and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph, sician Clostridium Difficile Colitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
 5 Other (specify) Day Month Year Pregnant at time of death 1 ☐ Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Kidney Disease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Type II Diabetes Mellitus autopsy perform death? Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Division of Vital Records, P.O. Box 68760

27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending

ficate:	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28d. Describe how injury occurred	
I Certi	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	(Check 2	Medical Examine	r: On the basis of examinatio	n and/or investigation, i	in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner st place, and due to the cause(s) and manner as stated.

only one) 3 Certifying Nurse Practitioner: To the best of my knowle		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
I mo	00059107	07-13-2012

Name and address of person who co	ompleted cause of death (Item 23a) (Type, Print)			
KALU UMA	210 BUSINESS CENTER	DRIVE	, REISTERSTIONN	mo 21136
1. Date filed (Month, Day, Year) 1111 23 2012	32. Registrar's Signature	,	,	

State

Registrar

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ Carlton Lasley Sexton 201 1:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balt<u>imore</u> Blakehurst Retirement Community Towson 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. 265-28-9726 **Director** 1 X M 2 🗆 F 87 Feb. 18,1925 Florida Usual Residence of Decede 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland at Director notified 1 🗌 Yes 2 🔽 No Maryland Stevenson Baltimore 10e. Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 3436 Halcvon Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. "natural", or iter dical Examiner Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event" *** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Neil1 Berniece Sexton Carlton Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 22015 19a. Informant's Name/Relationship (Type, Print) 10335 Mockingbird Pond Court Burke, Virginia Polly S. Barlow Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of Stremetel normals by the Diesocopal 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8-4-2012 Owings Mills Maryland Church Cemetery 4 Donation 5 Other (Specify) 21. Sign ture of Fynexal Squice Lice 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ementia ears Sequentially list conditions Examine if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Be (ᅆ

Records, P.O. Box 68760 Division of Vital

Baltimore, Maryland 21215-0036

				1	✓ No 3 ☐ Probably 4 ☐ Unknov	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical			ck only one)	only one)		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	ome 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred	
3 Suicide 6 Could not le 4 Homicide determined	280 Place of Injury - At he		ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

04717

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wonell

, 6301 N. Charles St

State Registrar

Certificate:

Medical

29a. Certifier

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 16^{ay} Shuev 20^{Year}2 Margaret Jane 1:43 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arundel 2411 229th Street Pasadena Anne Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. **Director** 214-12-8377 1 M 2 X F 90 Feb. 8,1922 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location must be notified at Director Maryland Anne Arundel Greenland Beach 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 106 Greenland Beach Road 21226 USA items 2 Page 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Sales Representative Jewelry/Clothing 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ဂ္ Carrol1 McKenna Johanna Riede1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda F. Grunder(Daughter) 2411 229th. Street Pasadena, MD.21122 Department of Healtl Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Haven Mem.Pk.July 24.2012 Glen Burnie, MD. 21. Signature Funeral Servic 22. Name and Address of Facility McCully-Polyniak Funeral Home, Polyni Valerie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequ **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a con-Exami burial-tran Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Hospital "r Attending Physician: The law requires that the death certificate be 24 hours effer death. Box 68760 as the IF FFMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months
1 Yes 2 No detached for Month Dav Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € 9 ☐ Unknown the 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of reuse of death?

1 Yes 2 No 24a, Was an After this certificate has funeral director, page 2 autopsy performed? filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Daughter's Home 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation within 24 hours after deat To the Funeral Directors completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical retrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Check only or 296. Signature and title of certifie 30 Name and address of person who completed

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ STER rachtmar 304 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himore Johns Hopkins Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number (In vrs. last birthday) **Funeral** 6. Sex 7. Age (Month, Day, Year) Months Min 088-26-2421 **Director** 1 XM 2 F 78 4-11-1934 New York Usual Residence of Deced shov 10a. State at 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be Funeral with 1395 Stratton Drive 20854 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S.
Armed Forces?

1 Xes 2 No Korean
If Yes, Give
Year or Dates. Conflict Black, White, etc. ö þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Labor Relations Specialist Training Company and the and in the art that the art the art that the art the art that the art that the art that the art the art that the art the art that the art that the art that the art the art that the art that the art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Trachtman Ann Lipkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerdy Trachtman - Wife 1395 Stratton Drive, Rockville, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 0 Department of Important: If any injury or once, Garden of Remembrance 7-22-2012 Clarksburg, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction . Signature of Funeral Service Licenses Brad Smetzer 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final PNEUMON Physician/ disease or condition resulting in death) DAY Medical Due to (or as a consequence of) **Examiner** MYELVIP EUXEMIA Sequentially list conditions. Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FFMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Year Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an s certificate has be director, page 2 s prior to completion of cause of death? performed? Yes 2 X No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending М 1 Tes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Sigrature and title of certifier 29c. License number

b

State 31. Date file
Registrar

Lana

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Md

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State	of M	arylan				lealth and l	Mental Hy	/giene	20	1-2	2325
	_	Registrar 1. Decedent's Name	e (Einst Middle	1 251			Ce	rtifica	te of L	Death	T a D	Reg. N	o. 2 U	1 4	
Physicia		Vicky	e (i iist, iviidan	c, Last)	j	Dian	ne		Та	tes	2. Date of D		ay 201 ^Y	ear 2	3. Time of Death 12:20p M
Medic Examin		4a. Facility Name (if 3911 Gr						4b. City		Location of Death		40	c. County of	Death	<u> </u>
Funeral Director		5. Social Security No. 217–64 –	umber	6. Sex 1			ast birthday) Yrs.	If Und	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	irth ay, Year)	. 4	Birthp Count	lace (State or Foreign
0.1.20		Usual Residence of	Decedent			57			1		01 2	/	14		MD MD
Maryland 28a-f sho atified at	rector	10a. State MD	10b. County			10c. City	, Town or Lo	cation cimo	re					1	0d. Inside City Limits X 1
with the I 23a or 2 ist be no	Funeral Director	10e. Street and Nun		y Road				10f. Z	ip Code	215		10g. C	itizen of Wh		try?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marri 3 【▼Widowed	ied 2 🗌 Mar	12. Was D Armed 1 Yes,	Forces?	Ever in U.S				ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-	14. Race - Black, Specify:	White, e	
hours "natur dical l	plete	(Spe		nt's Education est grade complet		16a. Decedent's Usual Occupation (Give kind of work done during most of workin.					kina	16b.	Kind of Busi	ness Ind	lustry
within 72 giene. er than t, the Me	Completed	12th gr			(1-4 or 5	5+)	life. D	O NOT us	se retired)	Assoc.	ung	us	Post	al	Service
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2 should th and N 27 is ma trauma		19a. Informant's Na								and Number or Ru					
ige 1 and nt of Hea t: If item		Andre Dennis-Son 3911 Grantley Road, Baltimore, Md 21215 20a. Method of Disposition Marked Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3911 Grantley Road, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Park Memorial Park 7/24/2012 Woodlawn, Md													
mit. Pa bartme bortant injury		4 Donation 21. Signative of Fur			11	Pa:	1			Park // West	24/201	2 W	oodla	awn,	, Md
permit Depar Impor any in		Ken	MODE	Jokes -	Atro	aha	m 1	4300	Wab	ash Ave	, Balt	imc	re,	Md	21215
Physician/ Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):												Approximate Interval Between Onset and Death	
nfed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.										<u></u>			
be executed sician and burial-transit	<u></u>	resulting in death) Last Due to (or as a consequence of):													
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 124 hours after death. To the function the sterofor After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the buse completed filled in by the funeral director, page 2 should be detached for use as the buse to the buse that the page 2 should be detached for use as the buse the buse that the page 2 should be detached for use as the buse that the page 2 should be detached for use as the buse that the page 2 should be detached for use as the buse that the page 3 should be detached for the page 3 should be detached for use as the buse 3 should be detached for use as the buse 3 should be detached for use 3 should be 3 should be 3 should be 3 should be 4 should be	Physician/Medic	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months? ☑ No	4 🗌 P	ive Birth		I death 3	Ectopic Other		су			23d. Date Month		ery Day Year
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ig Phy ter this neral d	te: To	27. Manner of Death	h	28a. D	inpati ate of inju nonth, Da	iry	28b. Time of injury		28c. Injun work		ome 5 Res 28d. Describe			Specify)	
Attendir r death. sctor: Af sy the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	5 Pendii Investi 6 Could	gation not be	ace of Inj	ury - At ho	me, farm, st	M reet, facto	1 🗆	Yes 2 No	28f. Location	(Street a	nd Number o	or Rural	Route Number,
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the Hos hin 24 ho the Fun npleted	Medical	(Check 2 only one) 3	Medical I	Examiner: On the Nurse Praction	basis of e	xamination	and/or inve	stigation, in death occ	n my opinio urred at the	e time, date and pla	at the time, date	and plac	e, and due to	the cau	ise(s) and manner stated
5 Wit		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)								1					
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Registra	ar		1 23	2012	-cu	1 1	. 19 a								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 2012 Terrillion Carol 10:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital <u>Silver Spring</u> Montgomery Social Security Number **Funeral** Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 133-28-9147 1 □ M 2 🗶 F 76 Usual Residence of Decedent January 13, 1936 New York 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 ី No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral <u>3124 Gracefield Road Apt. KC 418</u> 20904 United States 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Accounts Receivable Schindler Elevator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Clifford Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen L. Terrillion / Son 9349 Sibelius Drive, Vienna, Virginia 22182 20a. Method of Disposition July 21, 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Montgonery or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 Crematorium. Inc. Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert and Adramphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Onset and D Years Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death Live Birth 2 Fetal death 3 Ectopic pregnancy requires that the death jo in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\subseteq \text{ No} \) Month Day Year 5 Other (specify) signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Squamous Cell Carcinoma Lungs 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an or Attending Physician: The law has le 2 autopsy performed?

1 Yes 2 X No. prior to completion of cause of death?

1 Yes 2 No page certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence 6 \(\text{Other (Specify,} \) 1 🗌 Yes 2 [XNo 욘 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my kin who go as attractioned at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 July 18, 2012 20 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Eugenio S. Machado, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

3110 Gracefield Road, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Carol Yesley 2012 2:25 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Hours **Director** 347-36-9468 1 🗆 M 2 🗴 F 66 10/28/1945 Illinois 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Gaithersburg Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 U.S.A. 1115 Main Street 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces þ 1 Yes 2 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. 3 Widowed 4 Divorced Completed Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Social Worker Government Ith and Mental Hygie 27 is marked other traumatic event, 世 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bertha Morgan Eli Luskin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i 1115 Main Street, Gaithersburg, Maryland 20878 Joel Yesley - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ò Department Important: If any injury or Garden of Remembrance 07/23/2012 | Clarksburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Uterine Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) inding physician and use as the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month 5 Other (specify) Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPice ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider injury 5 Pending Work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

24 hours after death.

Funeral Director: After this certifica
etely filled in by the funeral director, Medical To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller. 6001 Muncaster Mill Road, Rockville, Maryland 20850 CRNP. 31. Date filed (Month, Day, Year) State Registrar 2 3 201 DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Walker Ardella :30 A M 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST TOWSON Baltimore 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 218-28-4300 Director 1 □ M 2 🗶 F 77 Yrs. 10-03-1934 MD Usual Residence of Decedent or then "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 X Yes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral lork Road - Apr 21212 USA 5220 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black White etc. δ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 end 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If them 27 is merked other then "eny Injury or other treumetic event; the Magnee. Elementary/Secondary (0-12) College (1-4 or 5+) STATE OF Maryland aregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Scott GREEN Edward rdella 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Baltimore, Md Cemetery Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN CREENE FUNERAL SCVS PA 21. Signature of Funeral Service Licensee Butimore, Md. 21212 York 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONATE COR Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires thet the death certificete be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlal-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHMINIC KIDNEY DUFASE, 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No <u>ا</u>و 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Periding work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

CHARIES

M

6701 N. Charles

Towson

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 12:10 P.M JULY 2012 MARY JANE WENTZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST CENTER TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 8/16/1922 Hours Director 165-22-1168 Usual Residence of Dece 1 🗆 M 2 💢 F PENNSYLVANIA 89 Yrs. 28e-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director TOWSON BALTIMORE 1 Yes 2 Xio 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 23a 1124 GREEN ACRE ROAD 21286 USA Page 1 and 2 should be filed within 72 hours after death ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo Specify: 3 Widowed 4 Divorced Completed WHITE the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) YEARS **TEACHER** PUBLIC SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P ANNA BONGIRNO JOSEPH BIFANO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1124 GREEN ACRE RD. TOWSON, MD HENRY S. WENTZ/HUSBAND 21286 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury of once. CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 7/23/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO0217 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) DVANCED disease or condition resulting in death) WARS Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) is after death.

I Director: After this certificate has been signed by the ettending physician and ed in by the funeral director; page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last or Attending Physician: The lew requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death 2 D N6 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by REBRUVASCULA ACCIDON 1 🗌 Yes 3 Probably 4 Unknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed 1 ☐ Yes 2 ☐ No 25. Was case referred to edical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) State Registrar

1 XYes 2 No 10g. Citizen of What Country? Race - American Indian, Black. Specify: White 16b. Kind of Business/Industry Construction Margaret Elizabeth Schammel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9612 Wadsworth Drive, Bethesda, Maryland 20817 20c. Location - City or Town, State Baltimore, Maryland Approximate Interval Between Onset and Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: funeral director, Division of Vital Nursing Home 5 Residence 6 🗹 Other: Scene 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b, Time of Injury 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending within 24 hours after death.

To the Funeral Director: the 1 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 17, 2012 30. Name and address of person who completed cause of death (Item 23a). W Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

OCME

1650 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2012 9:23 PM July Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lorien Nursing & Rehabilitation Ctr Taneytown g. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Year) 926 Months Hours (Month, Day, Y Maryland 218-01-1320 85 Director Aug. Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Carroll Taneytown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 100 Antrim Blvd. 21787 U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Maryland Farm Bureau secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is menan injury or other. ည Marian Dotterer John D. Young Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21158 Stewart D. Young/ brother 2507 Youngs Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 7/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery Linwood, MD 21. Signature of Juneral Service Lies 22. Name and Address of Facility Hartzler Funeral Home athorine 310 Church St., New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Alzheime disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CELEPRONDS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) nding physician and use as the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ atten in the past 12 months?
1 Yes 2 No Month Pregnant at time of death been signed by the a should be detached f Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes _2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After of the funeral place on pleted filled in by the funeral place. work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation AccidentSuicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

DHMH 17 Rev 7/2009

only one)

arm white

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

M. PANSURIFA, 349 Malcolin DR. Westminster, MD 21157

051705

29d. Date signed (Month, Day, Year)

07-17-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			_ State Registrar		Cer	tificate c	f Death			Reg. No.	201	2	23261
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						Date of Dea Month		√ Year	,	3. Time of Death
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	Examin	er	4a. Facility Name (if not institution, give street and				n, or Location o	of Death			County of De		
•• ./	Funeral		GILCHRIST HOSPICE CAR 5. Social Security Number 6. Sex	7. Age (In yrs. lá	ast birthday)	TOWS		24 Hrs.	8. Date of Birtl		BALTIM 9 F	-	ce (State or Foreign
	Director		217-22-6208 1 🖾 M 2 🗆]F	Yrs.	Months Da	ays Hours	Min.	(Month, Day	, Year)		Country	
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	or 28	Dire	MD BALTIMORE 10e. Street and Number	I BA	LTIMOR	10f. Zip Co	de			10g. Citizen of What Country?			
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	tems er mu	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S		21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						nericar	Indian,
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Jar	should h and Me 7 is mar raumati		19a. Informant's Name/Relationship (Type, Print)		II.		eet and Numbe					•	•
	and 2 Health em 27		SHIRLEY WEISBERG / W 20a. Method of Disposition	IFE LOOK B	•		POST DR						
Baltimore,	Page 1 nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal	from State	emetery, crem	sition (Name o	place)		ate		cation - City		
量	permit. Page 1 Department of Important: If i any injury or once.		4 Donation 5 Other (Specify) 21. Signature of In Service Licensee	B.		RE HEBI			/2012	RI	EISTER	STO	WN, MD
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	To the within comp	~	29b. Signature and title of certifier		.,ougo,								
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	101		30. Name and address of person who completed	cause of death (Item	23a) (Type, Pi	rint)	1583	a (7	- Jous	ov	MI)		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12. 05:25 PM 2 ulke Imest 2013 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 321-26-1078 Illinois 79 August 4, **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a State must be notified at 1 Yes 2 No Director Edgemere Baltimore Maryland 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö 21219 USA 2405 Oak Manor Road 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 XMarried ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: þ 3 Widowed 4 Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) than Elementary/Secondary (0-12) Bethlehem Steel Information Services 12 years permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Ida Frances Drane Ernest Robert Zulke Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2405 Oak Manor Road, Edgemere, Maryland 21219 wife Patricia M. Zulke 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 20, 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Jun val Service Licenses Connelly Funeral Home Of Dundalk, P.A. suporu 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease for complications that caused the death. Op not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Due to (or as consequence of): **Physician** disease or condition resulting in death) /Medical Examiner COronary avten Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sons equence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 - Fetal death 3 - Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Vunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Jas 2 □ No 1 TYes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 2 Accident 1 🗌 Yes 2 🗌 No death. 24 hours after death Funeral Director: A filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital 29a. Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature a

30. Name and addr

title of certif

within 2

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32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 3 2012

s of person who completed cause of death (Item 23a) (Type, Print)

CIM moto

29c. License number

res-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Affred, R, Allegra Physician/ Month O'7 18:07 201 Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical Center 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. Director 578-44-6000 1 X M 2 🗆 F JAN. 27, 1936 WASHINGTON, DC show 10a. State 10d. Inside City Limits 10c. City, Town or Location notified at Director CENTREVILLE 28a-f MD OUEEN ANNE'S 1 X Yes 2 - No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 21617 USA 840 HARMONY WAY items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 2 X No Yes Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) DISTRIBUTION WAREHOUSE OWNER 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ပ ALFRED ALLEGRA CAROLINA KESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 840 HARMONY WAY, CENTREVILLE, MD 21617 1 and 2 s of Health item 27 i SANDRA F. ALLEGRA/ WIFE other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. CHESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State JULY 6, STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of uneral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aartic Stenosis Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 9 Unknown Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performe 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at Funeral Director; After stely filled in by the funer Hospital or Attending (Month, Day, Year) 5 Pending Natural death. 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 2 29b. Signature and title of cer Mona Beier 1538435219 4, 2012 Resident Physician. 0

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day Y

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mora Beier, 22 South Greene Street, Baltimore, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2012 JULY **Physician** 15 4:36 a^{M} EVELYN R. ARKINSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Talbot Wing - Heron Point Chestertown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5 1917 Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🔀 F May 95 Director New York 105-32-8230 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "Actical Examinar must be notified at 1 XYes 2 ☐ No Director Chestertown MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 21620 114 Heron Point Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X1Yes 2 No 1942 If Yes, Give 1 XNever Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1∐Yes 2**X**No Specify: ģ 3 Widowed 4 Divorced Year or Dates: -1945 Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Public Health 4 Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Mildred Harvey Thomas Arkinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 Circle Dr. - West, Milton, DE. 19968 Kathy Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/12 Cedar Park Cemetery Hudson, NY. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
118 West Cross St. Galena, MD. 21635 M00510 Approximate Interval Between Onset and Death art. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or beart failure. List only one cause on each line. Immediate C se (Final disease or andition resulting i death) DEMENTIA >5 year ADVANCED **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 2**2**No Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 1 ☐ Yes 2 No 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

· ston

State Registrar Helen A. Noble, M.D. 122 Speer Rd.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

33. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chestertown, MD. 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:30 A^M Christine Louise Albright July 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 285 Greenwood Street E1kton Cecil 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 212-70-0282 54 1 M 2 XF 5/21/1958 MD or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Ceci1 E1kton 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral Page 1 and 2 should be filed within 72 hours after death with 285 Greenwood Street 21921 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 Divorced 4 Divorced er than "natur, 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Auto Dealership Secretary of Health and Mental Hygie fitem 27 is marked other r other traumatic event, tt other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William H. Biggs Betty L. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health John Albright - husband 285 Greenwood St. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If i any injury or conce. 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 7/9/2012 Chesapeake City, MD ral Service Licens 22. Name and Address of Facility R.T.Foard Funeral Home, PA ſ 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Physician/ Immediate Cause (Final Onset and Death 00 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Asthma Sequentially list conditions. if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier In clil Was

State

Registrar

31. Date filed (Month, Day,

Registrar's Signature

12-05258

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Kenneth L. Ad	iuiso	1- For S Registr		SI	ate of Maryl			rtment c tificate c			a Meni	аі нуді		eg. No.	2 U	12 2320
Physi Medical Exa				ne (First, Midd LEE AL	•							M	ate of Deat Nonth Lily 12, 20	Day	Year	3. Time of Death 1650 hrs
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and show	- E	MD		Monte	omery	S	Silv	er Spi	cing							1 Yes 2 No
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Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and 1 Important: If item 27 is 1			ristir ethod of Dis		.son/daugl		20b. P	978 V lace of Dispo				, Gal			, MD 20 ocation - City o	
Baltimore, permit. Pages I a Department of He important: If ite	one	1 X	Burial 2	Cremation	n 3 Removal f	rom State	cr	rematory or o	ther plac	ce)					·	
altin mit. Pa partmen		4 Donation 5 Other Specify: Ash Memorial Cem. 07/18/2012 Sandy Sp. 21. Syneture of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Hom								al Home	e					
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Examine	er		iate Cause (dition resulti	(Final disease ng in death)	Due to (or as			C.								
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Sox 6876 leath certificate e attending phy	Physician/N	1 D			4 Preg	nant at time	of dea	+ =	ther (Sp	pecify)				1		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ar death rector: After this certificate has been signed by the attending physician and	<u>ا</u>		Other signi	ificant condit			not res	sulting in the	underlyir	ng cause g	given in Par	t I.	23e. Did tol	bacco us	e contribute to	the cause of death?
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Division of Vital Records, talor Attending Physician: The law requir rs after death. Divector: Abler this certificate has been so talor than the control of the physician of th	polet	_											24a. Was a autops perforr	sy		utopsy findings available completion of cause of
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DIV To the Hospital or within 24 hours after To the Funeral Div	Medical C	29a C	ertifier 1		nysician: To the be miner:On the basis and manner:	of examina						ce, and due t	to the cause	e(s) and	manner as sta	ted.
H 3 F 3	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29b. Si		title of certifie	r				29	9c. Licens						onth, Day, Year)
		20 N-		ress of person	who completed cau	se of dooth	(Itam 1	23a)		O.C.I	VI.E.			July 1	13, 2012	
			ne and addr ng Li, MD	-	nt Medical Exa		-	-	re Stre	eet, Balt	imore, M	1D 21223				
State 31. Date filed (Month, Day, Year) 2012 37 Registrar's Signature Registrar																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 p.m 3:35 Agnes Burroughs July. 4, Mary Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** St. Mary's Avenue 38665 Ted Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min (Month, Day, Year, Director 219-56-0680 1 □ M 2 🛛 F 63 05/22/1949 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location must be notified at Director 1 ☐ Yes 2 🗓 No Maryland St. Mary's Avenue 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 38665 Ted Circle United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Marital Status Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 0 þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Alfred Trossbach Teresa Aud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Joseph A. Burroughs/Husband</u> 38665 Ted Circle, Avenue, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charles Memorial Cem 07/10/2012 Leonardtown, MD Significe of the relieving the second of the 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician Metastatic ovarian disease or condition resulting in death) rancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physiciar Physician/Medical The law requires that the death certificate be Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? 2 No 2 🗌 No 1 Tes Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After Natural work?
1 Yes 2 No 5 Pending Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital (24 hours a 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 5,2012 D71807 Sough A. John ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40900 merchanis in Ste 207 Leonard town, mo 20650 Sarah A. Johnson mo 31. Date filed (Month, egistrar's Signatur Year) State JUL 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ :30 2012 John Alton Burgess Ju1v q Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary's St. Charlotte Hall Veterans Home <u> Charlotte Hall</u> 9. Birthplace (State or Foreign Country)
Washington, D. r 1 Year Days 8. Date of Birth Funeral Hours Months (Month, Day, Year) 01/12/1932 1 X M 2 🗆 F 80 Director 577-40-9427 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 ☐ Yes 2 X No LaPlata Maryland Charles 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral S 20646 308 Hickory Circle Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2 □ No
If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 11 Printing Company Lithographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) other traumatic Lavinia Annie Reinburg Brainard Recker Burgess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Health an Important; If item 27 is any injury or other trau 308 Hickory Circle, LaPlata, MD 20646 Dolores Burgess/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 🗓 Cremation 3 🗀 Removal from State 7/10/2012 Charlotte Hall, MD 4 Donation 5 Other (Specify) Brinsfield-EcholsCrem Sign up of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed TEOARTHRITIS 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 2 1 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After work? 1 Natural 5 Pending Accident Investigation filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifi 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 pme State

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUL 12 2012

2. Registrar's Signa

Stephen Patrick Cafferty, 29449 Charlotte Hall Road, Charlotte Hall, MD 20622

State of Maryland / Department of Health and Mental Hygiene 20 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July $20 ilde{1} ilde{2}$ Edna Darner Butcher 3:02 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) 213-18-9413 1 🗆 M 2 💢 F Director Sept. 6,1917 Maryland 94 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show with Inury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 E. 2nd Street 21701 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Operator State Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Darner Elizabeth Roelke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Baldridge (Niece) 211 E. 2nd St., Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mt. Olivet Cemetery 1 XBurial 2 Cremation 3 Removal from State 7/9/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basiord P.A. Funeral Home 106 E. Church Street, Frederick, MD 21701 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Kectel 5 <u>000</u>5 Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Conquetive Heart Feelyn Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to or a la considuence of attending physician and I for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day been signed by the s should be detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?

1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After i filled n by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46248 5/2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha J. Pierce Mo 300 West 9th St Frederick MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature 6 20 MUNICIA Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roger Alistair Bell 2012 July 6:37 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Westminster Carroll Dove House If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 1 M M 2 🗆 F 215-46-4921 76 Yrs 16 1935 Sept. England 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Ashton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1500 Tucker Lane 20861 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Astrophysicist Education other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve should be William Ernest Bell Irene May Elsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Tucker Lane, Ashton, Maryland Sylvia A. Bell / Wife Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🔲 Removal from State 07/02/2012 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Virginia 21. Sign of Fu of Service 22. Name and Address of Facility Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner neumen Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to r as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant a Pregnant at time of death ned by the a 1 Yes 2 l 9 Unknown To the Hospital or Attending Physician: The law requires that the usultin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be Adache. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? out patient Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c License number 10102 01 012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rochelle Dyer stone ten 31. Date filed (Month, Day, Year State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 12
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 June 7:08 A Milton Lee Burdette Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Crows Nest Campground Frederick Thurmont 8. Date of Birth (Month, Pay, Year) Sept. 16, 1954 . Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Mary Land 57 Director 220-60-0458 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Frederick Adamstown 1 ☐ Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral Rt. 1, Ballanger Creek Pike 21710 United States 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ò Š 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 - Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. other than * life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Caning Company per nit. Page 1 and 2 should be filed wit De artment of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Melvin Burdette Childers Dena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Burdette, Jr. / Son Rt 1, Ballanger Creek Pike/Adamstown, MD 21710 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Stauffer Crematory 4 X Donation 5 ☐ Other (Specify) 07/05/2012 Frederick, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stauffer Funeral Home 104 E. Main St./ Thurmont, Maryland 21788 23a. Part 1. Priner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between disease Immediat Cause (Final Onset and Death ovon artu Physician/ disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): ending physician are use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Severe Chronio obstruema Pulmo Division of Vital Records, 2 No 3 Probably 4 Unknown Hypersersion, Hypertipidemia, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 2 🗆 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Thesidence 6 Nother (Specify) Campground 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAN-HING

DHMH 17 Rev 7/2009

State

Registrar

Box 68760

P.O.

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ June 28 Judy Keller Burkley Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Laurelwood Healthcare Center E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months Days Hours 1/16/1931 Director 212-26-6998 PAUsual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No E1kton Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 USA 2 Winding Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give White 3 Nidowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Elm Arthur Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Delphi Court, Bel Air, MD 21014 Wendy Barry - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) any injury 7/3/2012 Elkton, MD Elkton Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility R.T.Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ years disease or condition resulting in death) Medical Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conseq The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hypertension 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 🗹 No Other: 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 _ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

29b. Signature and title of certifier

31. Date filed (Month

9 Ohders

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. Sachdev MD 126A, E Thick of

20023322

ElkIm MD 21921.

29d. Date signed (Month, Day, Year) $7 \cdot 2 \cdot 20/2$.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Elizabeth Jane Brooks 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death edin/sula REGIONAL 544156414 HICIMICS If Under 1 Year If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) Director 221-24-8805 1 □ M 2 🖾 F 74 July 20, 1937 Usual Residence of Decede New York or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No DE Delmar Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36796 St. George Road 19940 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify 3 XX Widowed 4 Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) <u>owner/operator</u> daycare center Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Ward Clarice Shipman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health sitem 27 i Melissa J. Malone (Daughter) 38642 Woodside Court Delmar, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any Injury or of once. 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery 7-7-2012 Seaford, Delaware 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee 19940 Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of Injury that initiated events Examine Due to (or as a consequence of): the attending physicien and thed for use es the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: ves, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day signed by the at Id be detached for 5 Other (specify) 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Arter this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 W No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00070129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL STREET, SALISBURY, MD 21804 MOINUDDIN IRFAN 100 EAST 31. Date filed (Month, Pay, Year)

Registrar DHMH 17 Rev 06-2011

State

32. Registrar's Signature

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23277 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Day 2012 Year Physician/ Cook Genevieve Doris 4:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Renaissance Gardens at Riderwood Village Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 485-16-9501 Director 1 ☐ M 2XXF 86 Oct. 12, 1925 IΑ if and a succession of the subsection of the sub 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD P.G. Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 USA 3160 Gracefield Road, Apt. ET2208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lois Miriam Hayzlett Arthur A. Satterlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen C. Schmidt/Daughter 301 Waterford Road, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 9, 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Important: If any injury or once, Wilson Cemetery 4 Donation 5 Other (Specify) 2012 Independence, IA 21. Signature of Funeral Service Licens Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cor Pulmonale vears Sequentially list conditions, if any trading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consumence of Exami inding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending it accompletely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 X No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Atrial Fibrillation, Syndrome Inappropriate Antidiuretic 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hormone autopsy 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 SNursing Home 5 Residence 6 Other (Specify) Hospital မ 1 🗌 Yes 2XXNO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No М ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Plurse Plactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and tle of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar's Signature

Eugenio Machado, MD

06 2012

31. Date filed (Month, Day, Year)

D24035

3110 Gracefield Road, Silver Spring, MD 20904

July 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mabel T. Chaplin 7:25AM 30 2012 06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Hospice Dicomice 15 bur If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Min. (Month, Day, Year) **Director** 577-64-3332 1 □ M 2🏋 F 64 9-6-1947 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location the Marylend 10d. Inside City Limits Director MD 1 ☐ Yes 2 🕅 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral end 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. Iem 27 is marked other than "natural", or Items 23a 413 Bailey Lane 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Spedulack 1 ☐ Yes 2X No Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Mabel Chapin Elementary/Secondary (0-12) College (1-4 or 5+) 6 Teacher Prince George Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Boyd Barnett Vivian Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Chaplin/Son 1703 Wilson Lane, Salisbury, MD 21801 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham VA Cem 7-11-2012 Cheltenham, MD 22. Name and Address of Facility 17 W. Isabella St. Bennie Smith Salisbury MD 21801 21. Signature Funeral Service Licensee elle Salisbury, MD 21801 Funeral <u>Home</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence off-Approximate Interval Between Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and defeached for use as the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 1 Yes 12 No 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) to Spice at 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of take 28d. Describe how injury occurred 28c. Injury at V ☐ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Definition of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 63199 30/12. 3TE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOHRA 910 EASTERN SHORE DR. SALISBURY, MD OGESH 31. Date filed (Month, Day, Year) State 05 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Department of Health a State of Maryland / Department of Health a State of Maryland / Department of Health a Certificate of Death	ind Mental H	lygiene Reg. No.	2012	23	279
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Elinor Lannan Claunts	2. Date of Month July	Death	2012 ^{Year}	3. Time of 4:15	Death P M
	Medic Examin	al	4a. Facility Name (if not institution, give street and number) Clifton Woods Group Home 4b. City, Town, or Location of Silver Sprin	Death	4c. (County of Death		
الر.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 10.1	24 Hrs. 8. Date of Min. (Month,	Day, Year)	Cou	nplace (State o	r Foreign
	Director	_	454-86-9819 1 □ M 2 ☑ F 101 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	Feb.	5, 19	11 OK	10d. Inside Cit	ty Limits
	Marylan 28a-f st	recto	Maryland Montgomery Silver Spring				1 🗆 Yes	2 [™] No
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 15301 Montford Road 20905			zen of What Co SA	untry?	
99	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentel Hygiene. Important: If them 27 is merked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examination is notified at once.	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	in? (Specify Yes or Puerto Rican, etc.)		14. Race - Amer Black, White		
2-00	hours a	Completed	3 ☑ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of the complete of the complet	of working	16b. Kir	nd of Business/I	ndustry	
2121	within 72 giene. er than '	Com	Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 Homemaker		0	wn Home		
land	be filed lentel Hy rked oth tic event	To Be		r's Name <i>(First, Mid</i> y Estelle				
Mary	2 should th end M 27 is me r traumat		19a. Informant's Name/Belationship (Type, Print) Claun US Frank P. Calunts / Son 19b. Mailing Address (Street and Number 15301 Montford Roa	r or Rural Route Nul ad, Silve	nber, City or i	Town, State, Zip .ng , MD	^{Code)} 20905	
Baltimore, Maryland 21215-0036	Page 1 and nent of Hea int: if item iry or othe		20a. Method of Disposition 1	July 9,		cation - City or		
Balti	permit. I Departm importa eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Coll 500 University	ins Funer Blvd., W.	al Hom , Silv	e, Inc.	ng, MD	20901
	estate v		23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respirator	y arrest,		Approximat Interval Bet Mont and	te ween
	Medical Examiner		disease or condition resulting in death) A Tallure to Inflive Due to (or as a consequence of):				Years	5
		ner	Sequentially list conditions, if any, leading to immediate b. Alzeimer's Disease Due to (or as a consequence of): Due to (or as a consequence of):					
	icate be executed physician end st the burlal-trensit	Exam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		2/4			
09	ate be ex ohysiciar the burk	dlcal	d					
Box 68760	Attending Physicien: The law requires that the death certificate be executed ar death. sctor: After this certificate has been signed by the attending physician end by the funeral director, page 2 should be detached for use es the burial-trensition.	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown		_	23d. Date of del Month		Year
ls, P.O.	uires that th n signed by uld be detac	<u>۾</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			se contribute to		
Division of Vital Records, P.O.	The law req ate has bee page 2 sho	Completed			Vas an utopsy performed? Yes 2 ☑ No	prior to death?	topsy findings completion of c	available cause of
ital	sicien: certific irector,	Be	examiner?	th (Check only one)		Xouthan (Casa	Group	Home
) of	ling Phy). After this funeral c	ate: To	27. Manner of Death 1 ★ Natural 5 Pending 28a. Date of injury 28b. Time of injury at work? (Month, Day, Year) 28c. Injury at work?	28d. Descr	be how injury			
ivision	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Locati	on (Street and Town, State)	d Number or Ru	ral Route Numi	ber,
۵	Hospital	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	curred at the time, d	ate and place,	, and due to the	cause(s) and ma	anner stated.
	To the within 2 Comple	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, dat 29b. Signature and title of certifier 29c. License number	te and place, and du	29d. Dat	te sign ed (Monti	n, Day, Year)	-
0	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			y 7, 20		
سر			Suresh K. Gupta, MD 9801 Georgia Avenue Ste. 220,	Silver S	pring,	MD 209	02	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 09 2012 37 Registrar's Signature					

State Regist<u>rar</u> MEDICAL

MAN NAING DO, MD

CENZER

BEL-AIR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAESAPEAKE

32. Registrar's Signature

NPPER

31. Date filed (Month, Day, Year)

2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Angella Davis Maria 07:00 Physician/ วัติ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges Community Hospital Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Months Hours Min 220-53-1196 **Director** 1 🗆 M 2 🕱 F 61_{Yrs} Apr. 12, 1951 Jamaica 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location notified at Director Landover Hills Prince Georges M D 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country must be 20784 United States 23a Funeral 71st 4404 Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc ŏ 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify. If Yes Give "natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Health College (1-4 or 5+) Elementary/Secondary (0-12) Licensed Practical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Nalda Lewrence မ William Taylor other traumatic s (Street and Number or Rural Route Number, City or Town, State, Zip Code) st Avenue, Landover Hills, Maryland 20784 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre **4404 71st** Department of Health an Important: If item 27 is any injury or with Dunstan D. Davis / husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 7/14/2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. of Fugleral Service Lices 7400 Georgia Avenue, NW, Washington DC 20012 22 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptoyuctan/ mmar disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 X No jo Month Day Pregnant at time of death 1 Yes 2 D the P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ဂ္ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 only one) 29b. Signature and trib 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 28d, per me, g931 9-5-12 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ellis Bernard C1eo 2012 11:49a M Ju₁v Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 22800 Lawrence Ave, Apt. C St. Mary's Leonardtown Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 217-42-0591 **Director** 1**X** M 2 □ F 72 01/25/1940 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No St. Mary's Leonardtown Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 22800 Lawrence Avenue, Apt. 20650 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give should be filed within 72 hours affer and Mental Hygiene. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Auto Mechanic Car Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John William Ellis, Sr. Edna Mae Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 20650 22810 Dorsey Street, Apt 207 Leonardtown, MD Lillian M. Prettyman/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If ite any injury or ot cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/12/2012 Bushwood, MD Sacred Heart Signature of Furieral Sonic licen 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick Street Leonardtown, MD 20650 Gardiner 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown P.O. signed k d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perforn Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? Hospital: Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 28b. Time of injury 28d Describe how injury occurred subject exposed to high environmental temperature 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 1 Natural 2 Accident 5 Pendina 7-8-12 42/Known Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) **22800 Lawrence Ave, #C** determined Leonardtown, MD 20650 At Home Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7-10-12 Jarry 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 25365 Point Lookout Road Leonardtown, MD William D. BoydII, 31. Date filed (Mon Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:45 P 07 09 2012 <u> Michael Shamir Eberhardt</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Hours **Director** 1 X M 2 🗆 F 215-06-6205 42 07/20/1969 Washington, DC show or 28a-f shov se notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County Director 1 ☐ Yes 2X No St. Mary's Leonardtown Maryland 10f. Zip Code 10g. Citizen of What Country? pe ral", or items 23a Examiner must be Funeral 41485 Norris Street, Apt.8 20650 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. **Black** "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Hospital 12 Nutritional Services is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille A. Foster Emanuel B. Eberhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41485 Norris Street, Apt.#8 Leonardtown, MD 20650 27 Crystal Lee_Eberhardt / Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Crem 7/16/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home P.A. Echols) M00817 30195 Three Notch Road Charlotte Hall, MD 20622 JAT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. MATORY Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): LEVKEWIA **Examiner** YEMAS Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Director as a nonsiturience of Cause (Disease or injury nding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: WW. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 🗌 Yes 2 No 3 Probably 4 Unknown or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy has performed 1 Yes 2 No Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be I examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 - No ဂ 1- Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ë within 24 hours after death. To the Funeral Director: After injury Natural 5 Pending Certifical 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56096 30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) MD TRINDER 32 Registrar's Signatur State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 7:20 P 7 Gwynette Ferguson July Agnes Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death St. Mary's St. Mary's Nursing Center Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 212-22-3447 **Director** 1 □ M 2**X**□ F 06/04/1926 86 Maryland Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Hollywood ŏ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? . Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be I Funeral 24393 Three Notch Road 20636 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker n and Mental Hygien 6 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Leonard Readmond Estelle Wallace Emma t. Page 1 and 2 should b trnent of Health and Mer rtant: If item 27 is mark njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Howe-Daughter 24393 Three Notch Road, Hollywood, Maryland 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/13/2012 Hollywood, Maryland Chapel Cemeterv Signal Service Unisee
Edward N. Brinsfield Jr. Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Principary Do Toses C MREMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of) nding physiciar Physician/Medical certificate be Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? ģ Month Day Year Pregnant at time of death signed by the a d be detached f 2 No Yes P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed pe**e**n 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 certificate has autopsy performed? 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural injury 5 \square Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

D)eme

State Registrar

completely

within 2

29a. Certifier

Check

only one

29b. Signature and file of certifier

Rajbinder S.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gil1,

M.D

Registrar's Signa

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

24035 Three Notch Road, Hollywood, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 9-12

20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year $J\mathbf{u}\mathbf{1}\mathbf{y}$ 8:00 A M Betty L. Ferguson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 215 Jackson Hall School Road Ceci1 E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 8/16/1929 Director 82 222-16-6533 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 215 Jackson Hall School Road USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc ρ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 K No Specify Specify: White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Wingard Georgia Sweetman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold E. Ferguson - husband 215 Jackson Hall School Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Head of Christiana Cem 7/6/2012 Newark, DE Anature Funeral Service Licensee 22. Name and Address of Facility R.T.Foard Funeral Home, PA 259 East Main Street, Elkton, MD 21921 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) and Stage Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burlal-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available page 2 s prior to completion of cause of death? performe cate l 1 ☐ Yes 2 ☐ No Yes 2 No certific Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ျာ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural 5 Pendina death. 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier H0062851

Registrar

DHMH 17 Rev 7/2009

State

3 3 GI
32. Registrar's Signature

EIKfm MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 2 CATHERINE GIAMANCO 07:00 a^M 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery 19524 Olney Mill Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min (Month, Day, Year) 94 151-07-6495 1 □ M 2 🔀 F Oct. 12 1917 New Jersey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Olney Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 19524 Olney Mill Road United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Food Store Cashier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Angelica Campano Vincent Ciarleglio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1007 North Main St., Mt. Airy, Maryland 21771 Vincent Giammanco/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖺 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 7/5/2012 Silver Spring, MD Gate of Heaven Cem. 21. Signature of Funeral Service License Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes outcome of pregna

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

MD

Director

Funeral

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Examiner

Funeral

Director

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events once.

Examir ending physician and use as the burial-trapsit Physician/Medical been signed by the sahould be detached 2 Certificate: To Be Completed eral Director: After this certificate has filled in by the funeral director, page 2. Medical

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🔲 Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco										
1 Yes 2 No 3 Probably 4 Unknow											
25. Was case referred to edical											
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 Residence	6 ☐ Other (Spec	cify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	28d. Describe how injury occurred						
3 Suicide 6 Could not be 4 Homicide determined			ory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,					
20a Certifier 1 Certifying Phy	sician: To the best of my know	ledge death occurred	at the time date and place	and due to the cause(s)	and manner as s	stated					

State Registrar

completely

only one) 29b. Signature and title of certifier

14 Robert

within 2.

H. Robert Birschbach, M.D. 201

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Dav. Year) 12/0/2

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Russell Ave., Gaithersburg, MD 20877

31. Date filed (Month, Day Y 32. Registrar's Signature RELAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of	Maryland /	Department			Hygiene	012 23287
			Registrar 1. Decedent's Name (First, Middle, Last)	-	Certificate	or Deatri		Reg. No of Death	3. Time of Death
	Physicia Medic		LLOYD Gi.	FFOR	0		Most	h Day	ZOZ ZOAM
	Examin		4a. Facility Name (if not institution, give street and numb			own, or Location	of Death		ty of Death
× .			884 Barnes Corner Road		1611-1-1	Rising			Cecil
	Funeral Director		5. Social Security Number 218-14-9056 6. Sex 1 M 2 D F	'. Age (In yrs. last bir	Months	Days Hours	Min. 8. Date	of Birth th, Day, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	91	Yrs.		May	22, 1921	Maryland
	yland f sho	tor	10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits
	e Mar r 28a- notifi)ire	Maryland Cecil 10e. Street and Number		R1S	sing Sun		1.0.00	1 ☐ Yes 2 🙀 No
	vith th	rall	884 Barnes Corner Road		101. Zipi	2191	1	10g. Citizen of	f What Country? U.S.A.
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.	Funeral Director		ent Ever in U.S.	13. Was Decede	nt of Hispanic C	origin? (Specify Yes or an, Puerto Rican, etc		ace - American Indian,
9	after d ", or i kamin	þ	1 ☐ Never Mamed 2 ☐ Married 1 ☑ Yes	2 🗆 No		No Specia		Specif	ack, White, etc.
3	atura	Completed	3 ☐ Widowed 4 ☒ Divorced Year or Dat	es. W.W.II	a. Decedent's Usual	Occupation			White Business/Industry
Maryland 21215-0036	n 72 h e. an "n Medi	dm	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-		(Give kind of work life. DO NOT use	done during mo	st of working	Farming	g Garage and
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משב	e filed y tal Hyg ed oth	To Be	17. Father's Name (First, Middle, Last)			18. Mot		iddle, Maiden Suman	ne)
ž	should be a and Menta		John K. Gifford 19a. Informant's Name/Relationship (Type, Print)	· · · · · · · · · · · · · · · · · · ·	h Mailing Addraga	Street and Num		a Edwards	State Zin Codel
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Ğ,	of Hear		20a. Method of Disposition 1 □ Burial 2 【 Cremation 3 □ Removal from 9		of Disposition (Name		Date		r - City or Town, State
Ĕ	Page tment tant: I jury o		4 Donation 5 Other (Specify)	nate	erris & C		07/03/1	2 Penr	nsylvania
Baltimore,	permit. Page 1.8 Department of P Important: If its any Injury or of		21. Signature of Funeral Service Densee	n.Sr	Lee A.	Address of Fac Patter	son & Son	Funeral F 21903-0766	Home, P.A.
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on eac			of dying, such a	s cardiac or respirat	ory arrest,	Approximate
	nysician/	ž N	Immediate Cause (Final disease or condition	herosol	erobe	CAZ	drovas	calas De	Onset and Death
	Medical Examiner		resulting in death) Due to (c	r as a consequence	e of):				
		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	ras a consequence	ect):				
	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						
	icate be executed \mathcal{G} physician and \mathcal{G} is the burial-transit	al E	resulting in death) Last Due to (c	r as a consequence	e of):				
09/	cate b physic	edical	d	<u> </u>					
8	certific inding use as	Σ.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	ome of pregnancy				23d. D	Pate of delivery
P.O. Box 68	death	Physician/M	1 Yes 2 No	irth 2 Fetal dea ant at time of death own					onth Day Year
o O	at the d by the	Phy	9 Unknown 9 Unknown Part II. Other significant conditions contributing to de		in the underlying c	ause given in Pa	rt I. 23e	Did tobacco use cor	ntribute to the cause of death?
	Attending Physician: The law requires that the death certificate be executed at death certificate has been signed by the attending physician and \mathcal{L} by the funeral director, page 2 should be detached for use as the burial-transi	d by			, , , , ,				3 ☐ Probably 4 ☑ Unknown
Records,	w requ	Completed					24a.		. Were autopsy findings available
S Y	sician: The law certificate has t lirector, page 2 s	E O						autopsy performed? Yes 2 No	prior to completion of cause of death? 1 Yes 2 No
	Physician: T r this certifica eral director, p	Be	25. Was case referred to medical examiner?		12h 16 <u>-2</u> 8		eath (Check only one	- (
<u>-</u>	Physi this c	<u>ان</u>	1 Yes 2 No Hospital: 1 1 28a. Date of	npatient 2 ER/C		A Other: 4 🗆		Residence 6 Ot	
בס	nding ath. : After e fune	cate		n, Day, Year)	injury M	work? 1 🗌 Yes 2		ribe how injury occu	red
Division of Vital	il or Attending Phy after death. Director: After thi d in by the funeral d	Certificate:	3 Suicide 6 Could not be	of Injury - At home, f g, etc. (Specify)	farm, street, factory,	office		tion (Street and Num or Town, State)	ber or Rural Route Number,
ś	oital or ours afte eral Dire								
	the Hospital or I hin 24 hours after the Funeral Dire	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the beside only one) Certifying Nurse Practitioner:	s of examination and/	or investigation, in m	y opinion, death	occurred at the time,	date and place, and d	lue to the cause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	1		License number			ed (Month, Day, Year)
9	10+		1 10001	1	\mathcal{L}	158	72	Vale	2,2012
-	IVA		30. Name and address of person who completed cause	/	(Type, Print)	- 05	1 66	-	2, 2012
	Sta	te_	31. Date filed (Month, Day, Year) 32. Re	gistrar's Signature	of un	15/0	700	7 PYRU	17 -1 04
	Registra		002 0 3 20 12 b	Cesara	A. Sack	2			

Lloyd A. Grant

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nk Unk		State of Maryland /				nd Mental	Hygiene	20	12 2328
		Registrar	Cen	tificate o	Deam		R 2. Date of Dea	eg. No.	3. Time of Death
Physici ledical Exami		1. Decedent's Name (First, Middle,Last)					Month	Day Year	2218 hrs
		Lloyd Andre Anthony Grant 4a. Facility Name (if not institution, give street and number)			4b. City, Town, o	or Location of De	June 26, 2	4c. County of De	
		Sinai Hospital			Baltimore				
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Ye	ar If Under 24	Hrs. 8. Date of Bi	rth (MM/DD/YYYY) 9.	
Director		088-92-0768 1K M 2 F 3	8	Yr	Months Da	ys Hours I	Min. April		eign Country) anna 1) c a
		Usual Residence of Decedent			<u> </u>		1	, 3 (amarca
Any		10a. State 10b. County	10c. City,	Town or Loca	tion				10d. Inside City Limits
nyland sa-f show st once.	5	NY Kings	Broo	oklyn					1 XYes 2 No
Aaryland 28a-f sho 1 at once.	Director	10e. Street and Number		-	10f. Zip Code		1	l0g. Citizen of What C	ountry?
the land		5908 Snyder Ave.			1120	3		U.S.A.	
h with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	Ever in U.S		as Decedent of H Yes, specify Cuba		(Specify Yes or No erto Rican, etc.)	14. Race - Am White, etc	nerican Indian, Black,
or ite	핕	1 Yes 2	X No				,		Black
s afte	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com	plotod)	16a Docado	Yes 2 N		of work done	Specify: 16b. Kind of Busines	
natu Exar	ted	Elementary/Secondary (0-12) College (1-4 or 5			nost of working lif			TOD. KING OF BUSINES	Sort Radistry
36 bin 73 e. ethan	ple	12	´	Ва	arber			Hair St	yle
d wit	Completed	17. Father's Name (First, Middle, Last)		•		18.Mother's Na	me (First, Middle,		
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be (Cecil Grant				Lorna :	Fearon		
21 ould d Mer s man	ဥ	19a. Informant's Name/Relationship (Type, Print)						mber, City or Town, St	ate, Zip Code)
MD and 2 shoulth and 17 is summati		Lorna Fearon (Mother)	T					NY 11203	
s 1 an of Hea		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from Sta	te 20b. P	lace of Dispo rematory or o	sition (Name of co ther place)		Date	20c. Location - City	or Town, State
Page nent c		4 Donafion 5 Other Specify:		_	emetery		/28/12	I	n, Jamaica
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewith man and a statement of Health and Mental Hygiewith and "antural", or items 23a or 28a-f she injury or other transmatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service Licenses		²² M	Name and Address	ss of Facility tan Fun	eral Serv	vice	
		23a. Part I. Enter the disease, or complications that caused	the death	5.	517 Vine	St.,	Alexandri	ta, VA 223	Approximate Interval
Physician Medical		failure. List only one cause on each line.			ine mode or dying	, odd, do odi did	o or respiratory air	cot, shoot, or hour	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunsho Due to (or as a conse							
		Sequentially list conditions, b	,	,					
	Je .	if any, leading to immediate cause Enter Underlyin, Cause	quence of)):					
D	Examiner	(Disease or injury that initiated events resulting in death) Last	quence of)):	_				
executed an and al - transit	ũ	d							
ੂ ਜਾਜ਼	dical	UNPENDED AMENDED							
lox 68760, eath certificate be e attending physicia for use as the burial	/Me	IF FEMALE: 23c. If yes, outcom	e of pregn					23d. Date of deliv	•
68 certifi nding se as	ian	past 12 months?	time of dea	*h - =	etal death 3 ther (Specify)	Ectopic pre	gnancy	Month	Day Year
Box 68760, e death certificate be the attending physicied for use as the buried for use	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown		3 0	ther (Specify)				
O at the d by the stacke		Part II. Other significant conditions contributing to death	but not re	sulting in the	underlying cause	given in Part I.			to the cause of death?
i, P.O ires that to signed by 1 be detact	d by						_ 1 Ye:	s 2 ✓ No 3 ☐ P	robably 4 Unknown
rds requi	Completed						24a. Was autop		autopsy findings available to completion of cause of
eco he law ate has	mo						perfo 1 ✓ Yes	rmed? death	
tal Rec	BeC	25. Was case referred to medical			26.Plac	ce of Death (Che	ck only one)		
Vita nysicia this ce	To B	examiner? 1 ✓ Yes 2 No	nt 2 🗸 I	ER/Outpatien	t 3 DOA	Other ₄ Nu	rsing Home 5	Residence 6 Ot	her:
I Of ing Pl After unera		27. Manner of Death 1 Natural 5 Paneling Jun 26, 2012	ry ear)	28b, Time of 2154 hrs		ury at Work?	28d. Describe Subject sho	how injury occurred	
ttend death.	atio	2 Accident Investigation				Yes 2 ✔ No			. 2. J.
Division of Vital Records, prial or Attending Physician: The law require ours after death. Freal Director: After this certificate has been si filled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Inj			et, factory, office	building, etc.	or Town, S	State)	Rural Route Number, City
Spita hours neral		4 W Homicide determined (Specify) Loc 29a. Certifier 1 Certifying Physician: To the best of my						folk Avenue , Baltir	·
Division of Vital Records, P.O. Box 68760, with Electrical properties that the death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral Director; page 2 should be detached for use as the buri	Sal	Check only one) 2 Medical Examiner: On the basis of examiner							
To To	Medical	and manner stated. 29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed ()	Month, Day, Year)
4	1.5-11	Carol Hallan			0.C	.M.E.		June 27, 2012	
		30. Name and address of person who completed cause of de	eath (Item :	23a)				1	
		Carol H. Allan, MD Assistant Medical Ex		900 W.	Baltimore Str	eet, Baltimo	re, MD 21223		
	tate	31. Date filed (Mento, Day, Year) 2012 32 Registrar	- 40	ATTENDED	Ked.				
Regis	trar	OUL UD CUIZ KRIENA	p.	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 07704/2012 8:40P Ronald Edwin Greigg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6622 Wilson Lane Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 215-50-4458 **Director** 1**X** M 2 □ F 66 06/29/1946 Washington, DC 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 XYes 2 ☐ No Montgomery Bethesda 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g, Citizen of What Country? Funeral United States 6622 Wilson Lane 20817 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 Nol 969—
If Yes, Give 1075 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 1975 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o မ Edwin Ellsworth Helen Marie Marcy and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Patricia Anne Greigg / Wife 6622 Wilson Lane Bethesda, MD 20817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date Shannon Cemetery Donation 5 Cher (Specify) Moultonborough, NH 07/23/2012 22. Name and Address of Facility Joseph Gawler's Sons LLC. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the discusse, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Esophageal Cancer Physician/ disease or condition resulting in death) 18 Months Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the buria attending physician Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 😾 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed' death? 2 X N 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the Funeral Directors. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2X No Other: ပ 1
Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending Accident Investigation 6 Could not be pletely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0061040 07/05/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Rudin MD 401 North Broadway Baltimore, MD 21231

State Registrar 31. Date filed (Month, Day, Year)

JUL 09 2012

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene											
			State Registrar	Cer	tificate of D	eg. No. 20	2 23291				
	Physicia	in/	Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death		
~	Medic	al	David Paul Herring 4a. Facility Name (if not institution, give street and number)		4h City Town or	Location of Death	July	Day Year 1 2012 1:24 P. M			
and the same of th	Examin	er	Upper Chesapeake Hospital		Bel Air	Location of Death		Harford			
	Funeral			ge (In yrs. last birthday)	If Under 1 Year Months Days						
	Director		215-36-5967 Usual Residence of Decedent	71 Yrs.	Worth's Days	TIOUIS IVIIII.	12/01/19	** **			
	ind show at	ě	10a. State 10b. County	10c. City, Town or Loc	ation		12/01/13	740	10d. Inside City Limits		
	Maryla 28a-f s	Director	MD Harford	Edgewood					1 ☐ Yes 2 🔀 No		
	a or 2 be no		10e. Street and Number	•	10f. Zip Code		11	0g. Citizen of What	Country?		
	th with ms 23 must	Funeral	909 L. Woodbridge Ct.		21040			USA			
10	2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Fu	11. Marital Status 12. Was Decedent Armed Forces? 1 🖾 Never Married 2 🗌 Married 1 🖾 Yes 2 🗀	Ever in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
036	rs afte rral", Exan	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 1	☐ Yes 2 H No	Specify:	Specify: White				
2-0	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa ind of work done d		ina	16b. Kind of Business/Industry			
121	iled within 72 il Hygiene. I other than ' vent, the Me	Som	Elementary/Secondary (0-12) College (1-4 or	5+) life. DC	NOT use retired)						
d 2	led w Hygi other rent, t	Be	17. Father's Name (First, Middle, Last)	acc	ountant	18. Mother's Nam	e (First, Middle, Ma	accou) aiden Surname)	nting		
/lan	should be filed n and Mental Hy, 7 is marked oth raumatic event	2	Brooke Herring			Coenia	Shoemake	er			
lan	should and I is ma	1))	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	nd Number or Run	al Route Number, (City or Town, State,	Zip Code)		
e,	ge 1 and 2 should be nt of Health and Men it if item 27 is marke or other traumatic		Jean Hoffman/sister 20a. Method of Disposition		oney Parl	-1.		_{ID} 21788			
nor	Page 1 nent of I ant: If its ury or of		1 🗌 Burial 2 🛛 Cremation 3 🗀 Removal from State		atory or other place	9)		20c. Location - City			
Baltimore, Maryland 21215-0036	4 5 2 5		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Stauffer	Cremator Name and Addres	s of Facility C+	7/2012 3	Frederick	mes, P.A.		
ñ	permi Depar Impor any ir	b	1 (2 2 9 . M	10	621 Oposs	umtown P	ike. Fre	dneral no derick, M	mes, P.A. D 21702		
П			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	d the death. Do not ente					Approximate Interval Between		
	Physician/	1	Immediate Cause (Final disease or condition	shable,	mo care	dial i	forct	ion	Onset and Death		
Ì	Medical Examiner		resulting in death) Due to (or as	a consequence of):	4						
	SEE .	Jer	Sequentially list conditions, b. Dak to or as	a nonequence bij:							
	d ansit	amìr	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
	ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as	a consequence of):							
09	ate be	dica	d								
687	ertifica ding pl	/Me	IF FEMALE: 23c, If yes, gutcome	of pregnancy							
XO	requires that the death certifics been signed by the attending p should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant 2 Pregnant 3	of pregnancy 2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)	/		23d. Date of a Month	Day Year		
O. B	the de by the	hys	9 Unknown				-				
P.	s that gned I		Part II. Other significant conditions contributing to death t	out not resulting in the ur		en in Part I.			to the cause of death?		
rds,	een sj	ted	CAY (RECEIO	(west lac _	12als		1 🗆 Yes	s 2 No 3 No			
000	has b re 2 sl	Completed by					24a. Was an autopsy perform	prior t	autopsy findings available o completion of cause of		
Ä	sician: The law r certificate has t director, page 2 s		25. Was case referred to medical		00 DI-		1 \(\text{Yes} \) 2		res 2 □ No		
Vita	/sicial s certi directe	To Be	examiner? Hospital:	ient 2 ER/Outpatient	Otho	r:		nce 6 🗆 Other (Sp	onifel		
of	ig Phys ter this neral di		27. Manner of Death 28a. Date of inju	ry 28b. Time of	28c. Injury work?	at	28d. Describe how		ecny)		
on	tendin eath. or: Af the fu	ifica	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	,, reary		Yes 2 □ No					
Division of Vital Records, P.O. Box 687	or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,		
Ω	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ical	29a. Certifier 1 rtifying Physician: To the best of	my knowledge, death o	ccurred at the time,	date and place, a	nd due to the caus	se(s) and manner as	stated.		
Cause (Disease or injury to group of the property of the prope								place, and due to th	e cause(s) and manner stated.		
_									,		
			100h.	least (harris 22) = =		5722	,	71	2/2012		
	(x)		30. Name and address of person who completed cause of a feeting Scarce to Jan	leath (Item 23a) (Type, Pr	int) "OO Unor-	Chesan	rake Dr	Bell	Ki MI 21014		
	Stat		31. Date filed (Month, Day, Year) 32. Registr			7) 0-17	1		
	Registra	ar	JUL 0 6 2012	un p. g	ares				2		

m800 Ulasses] Herring, David Dob 7/1/12 TOD 1324

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2012 June 28, 11:25 AM RUTH ELIZABETH HARDING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Walkersville Glade Valley Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 219-05-9439 Director 1 🗆 M 2 🔀 F 95 Dec. 18 1916 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location Director Frederick Frederick MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or than "natural", or items 23a or the Medical Examiner must be Funeral United States 21704 3716 Hope Commons Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture Farmer other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed hand Mental H is marked of ဂ္ Ε. Anna Charles R. Hawkins, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21704 3716 Hope Commons Circle, Frederick, MD If item 27 Marlene H. Breeding/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or oth cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Burtonsville, Maryland 07/03/2012 4 Donation 5 Other (Specify) <u>Burtonsville Union</u> 22. Name and Address of Facility Barber Funeral Home 21. Signature of Funeral Service, 20882 P.O. Box 5038, Laytonsville, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Stroke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying (or as a consequence of) Due to Exami that the death certificate be executed Cause (Disease or injury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 Yes 2 No Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔼 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 1 Natural 5 Pending after death.

Director: Af d in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 6-28-12

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

Records.

of Vital

Division

801

IOLL

House Ave, Frederick MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 32. Registrar's Signature

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Jacen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ Richard Sr. Medical 4b City(T) acility Name (if not institution, give or Location of Death Examiner 4c. County of Death 8. Date of Wirth (Month, Day, Year) 7. Age (In vrs. las birthdav) If Under 1 If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min Months Hours 216-30-3110 1 🕅 M 2 □ F Director July 22,1934 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Frederick 1 Yes 2 X No Md. Smi thsburg 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 14541 Old Catoctin Rd. 21783 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, an "natural", or ite Medical Examiner Armored Forces Black, White, etc. ģ 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Government of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) in and Mental h ပ Floyd Guy Hurley Catherine Clara Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy D. Hartman (Daughter) 14541 Old Catoctin Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a Method of Disposition July 23, ō Important; If it any injury or o once, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Peninsula Memorial Newport News, Va. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 AVIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) pheumonia Medical Due to ar as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Vear 1 Yes 2 9 Unknown the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 4 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No ■ Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🚣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) RES-000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Aaron Schuereman 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ $20\overset{\circ}{1}\overset{\circ}{2}$ $\mathbf{P}^{\,\mathsf{M}}$ 12 John Iannuzzi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 181-22-5552 Min (Month, Day, Year) 1 ★ M 2 🗆 F **Director** 3-23-1927 PA 85 Usual Residence of Decede or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be notified at Director 1 Yes 2 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral "natural", or items 23 United States 9772 Old Annapolis Road 21042 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ▼ Yes 2 □ No If Yes, Give 21215-0036 1 Yes 2X No Specify Specify White 3 Nidowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 5+ NSA Linquist Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental fitem 27 is marked (ည Maria Bortone Alessandro Iannuzzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Iannuzzi/daughter P.O. Box 334 Woodstock, MD injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Cathedral Cem. 07/21/2012 Baltimore, MD 22. Name and Address of Facilit Harry H. Witzke's Family FH, Inc. permit. Signature of Funeral Service Licenses any anito 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Due to (or as a consequence of) Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? 24 NO Other: 4 Nursing Home 5 Residence ပ 1 Inpatient 2 ER/Outpatient 3 DDA After this of funeral directions 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be filled in by the Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and title of certifier 19019 Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedor ane

DHMH 17 Rev 06-2011

Registrar

State

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an/ Medi		1- For State	Department of Health Certificate of Death	and Mental Hygiene	201	2 232
ali/ Nicui		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date (Month	of Death	3, Time of Death
Exam		John Thomas Jensen		July 1	1, 2012	1353 hrs
		4a. Facility Name (if not institution, give street end number)		m, or Location of Death	4c. County of Death	
		University of Md. Medical Co	enter		of Birth (MM/DD/YYYY) 9. Birth	polena (State or Enreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (1) 220-82-0259 1 1 1 1 2 F	in yrs. last birthday) If Under 1 Months Months			yland
		Usual Residence of Decedent	oc. City, Town or Location			10d. Inside City Limits
w any			North East			1 Yes 2 XXN
28a-f show	or	Maryland Cecil			10g. Citizen of What Count	
28a dat	Director	10e. Street and Number	10f. Zip Co			
3a or	ă	1569 Turkey Point Road		21901	United S	
pening, regge, 1 and 2 should be the winder of the common of the common of freath and Mental Hygiene. Importance of Health and Mental Hygiene. Importance if them 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the NEVEN Even mer must be notified at once,	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Event Armed Forces? 1 Yes 2		of Hispanic Origin? (Specify Yes Cuban, Mexican, Puerto Rican, el		
IL, D	by F	3 Widowed 4 Divorced If Yes, Give Year US			Specify:	White
atura	d b	15. Decedent's Education (Specify only highest grade comple		cupation (Give kind of work doneing life, DO NOT use retired)	16b. Kind of Business/In	dustry
n "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			D 11	
er th	ш	12	Mechanic		Railro	bad
Hygi d oth	ပိ	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Mi		
arke vent,	Be	Jens Jensen	19b, Mailing Address	(Street end Number or Rural Rou		7in Code)
ris m	ုင	19e, Informant's Name/Relationship (Type, Print)		Point Road, No		
alth a		Sarah L. Jensen / Spouse 20a Method of Disposition	20b. Place of Disposition (Name		20c. Location - City or	
of He		1 X Burial 2 Cremetion 3 Removal from State	1	July 7		
nent ant:		4 Donation 5 Other Specify	Cemetery	2012	Elkton, Ma	
eparts nport		21. Signal - Funeral Service 1. nsee		ddress of Facility Crouch		
- 7		23 Part I. Enter the disease, or complications that caused the	127 Sout	h Main Street,	North East, Mar	Approximate Interval
ysician Nedical		failure. List only one cause on each line.	deali. Do not enter the mode of dy	ing, score as cardiac or respirator	y an out, and on the same	Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consecution)				Codar
		or condition resulting in death) Due to (or as a consequence)	sence or).			
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		events resulting in death) Last Due to (or as a consequence)	uence of).			
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iaw requires that the cean certificate be executed has been signed by the attending physician and 2 should be detached for use as the bunal - transit	by Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 4a, 23c. If yes, outcome 1 Live birth 4 Pregnant at tim 9 Unknown	of pregnancy 2 Fetal death ne of death 5 Other (Specif	3 Ectopic pregnency y) use given in Part I. 23e	Month D Did tobacco use contribute to the Yes 2 X No 3 Prob Was an autopsy 24b. Were autopsy	ne cause of death? ably 4 Unknown opsy findings available ompletion of cause of
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To the Hopp fail of Attending Prhysican: The law Propures that the cean centificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit	cation: To Be Completed by Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the pest 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Xyes 2 No 27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending 1 X Accident Investigation of Could not be determined to the could not be determined to	2 Fetal death 2 Other (Specif) ut not resulting in the underlying cau 28 2 ER/Dutpatient 3 Do. 28b Time of Injury FOUND: 0713 hrs ry - At home, farm, street, factory, call Street	3 Ectopic pregnency 23e 24e 1 Place of Death (Check only one) A Other Nursing Home C. Injury at Work? 28d. De Opera 1 Yes 2 No office building, etc. 28f. Loc or and	Month D Did tobacco use contribute to the second s	ne cause of death? ably 4 Unknown opsy findings available completion of cause of s 2 No d in collision al Route Number, City Philadelp orth East,

6+IVA

Ana Rubio M.D., Ph. D. 31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

> 29c. License number O.C.M.E.

Registrar

July 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 0500 M 2012 Clara Mae Kehl Ju₁y Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perryville Cecil 423 Otsego Street Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) ec. 10 1 □ M 2 💢 F Months Davs Hours Min. Pennsylvania 1919 Director 92 197-07-5164 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits must be notified at Director Perryville 1 X Yes 2 □ No Cecil Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21903 423 Otsego Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in LLS Armed Forces?

1 Yes 2 X No Black, White, etc. 0 Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 ☐ Divorced White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Garment Nine Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Heddie Noss Harry Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Prueitt 423 Otsego Street, Perryville, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Elan Memorial Park 07/07/12 Lime Ridge,Pennsylvania 21. Signature of Funeral Service-Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Privician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner and I-transit Due to (or as a consequence of) resulting in death) Last been signed by the attending physician a should be detached for use as the burial-Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 1 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 1 ☐ Yes 2x No ☐ Yes 2 👿 No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pendina 1 Yes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Hospital Medical 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 30. Name and addre

pleted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Α. Knight 8:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3804 31st Street Mount Rainier Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country Wheeling Director 206-42-1987 53 1 ★ M 2 □ F 9/24/1958 Usual Residence of Decedent West, Va 28a-f show 10b. County 10c. City, Town or Location 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director MD Prince George Mount Rainier TXXYes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20721 USA 3804 31st Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Yes 2 K No Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes Give 3 Widowed 4 Divorced Specify. White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Director of Lending Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David G. Knight Rose Marie Shalvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mario Cisneros Partner 3804 31st ST Mount Rainier, Md 20712 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 X Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Blairsville W V Co. 7/5/12 MT. Morris, PA 21. Signature of Faneral Service Licansee 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 20016 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Year Immediate Cause (Final Ph. sician/ Esophageal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar for use as the buri Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death the g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo 1 🗌 Yes Other: ျဉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Presitioner: To the jest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) 10 MD0033293 7/5/12 30. Name and address of person who completed cause ath (item 23a) (Type, Print) 20815

Registrar
DHMH 17 Rev 06-2011

State

5454 Wisconsin Ave, Suite 1300 Chevy Chase MD

M.D., P.C.

Registrar's Signa

Frederick P. Smith,

06 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23298 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 2201P M ornelius Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death alisba Wicomic Deninsula Regional Medical Center Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Director 214-34-8187 1 X M 2 □ F Usual Residence of Decedent 75 MARYLAND 10/23/1936 i Hygiene. other then "natural", or items 23a or 28a-f show vent, the Medical Examirer must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No QUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 553 FEY ROAD 21620 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ **FARMER** AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F item 27 is marked o ည WILLIAM LOLLER MABEL PORTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH ANN LOLLER / WIFE PARK ROW CHESTERTOWN, MARYLAND 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Der artment of inportent: if it any injury or o 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION : 07/02/2012 | STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 cif 5 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease **Approximate** shock, or heart failure. List Immediate Cause (Final disease or condition Onset and Death CALDIOMYOPATT Physician/ Medical resulting in death) Examiner 4010VASCULAR Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Examine Due to (or as a consequence of) ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The lew requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 **X** No 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certified completely filled in by the funeral director, Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death updated at the time, date and place, and due to the cause(s) and name as stated. To the within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6/30 Mulales Capeur 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury, md. 21801 , chales Ogburn 100 E. Carroll St m3 31. Date filed (Month, Day

State Registrar

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ひし/シーのにimore, Maryland	Page 1 nent of int: If i		1 ☐ ★urial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State C6	emeterv, crer	veterans	Jul	y 6,2012		ear, DE	wii, otate	
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	Registra	tr	100 TO 5015	The same	-	6-11	-		_		_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ July Betty Louise Lamoreaux a M 4:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 221-12-9784 **Director** 1 M 2 X F 89 June 2, 1923 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director be notified MD Montgomery Potomac 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8205 Snug Hill Lane 20854 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces's If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by Page 1 and 2 should be filed within 72 hours after cament of Health and Mential Hygiene. Part If item 27 is marked other than "natural", or uny or other traumatic event, the Medical Examil uny or other traumatic event, the Medical Examil. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates, 1945-46 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Unknown McWilliams Addie Hester Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William T. Lamoreaux/Son 8205 Snug Hill Lane, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Lice Francis Address of Family ins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 3 upon...

y the attending physician and

''' use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth ☐ Pregnant a ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 🏖 No detached for Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No ٥ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certiffcate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation

Division of Vital To the Hospital or Attending Pleating 24 hours after death.

To the Funeral Director: After the completely filled in by the funera Betty PAUX, Lamor

Medical

Suicide

29a. Certifier

Homicide

6 Could not be

Ahmad T. Malik, MD

31. Date filed (Month, Day, Year)

determined

06 2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D71253

8600 Old Georgetown Road, Bethesda, MD 20814

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert J. Meier, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE AGN ES HOSPITAL None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 08/02/1945 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F 212-44-9464 66 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show notified at 1 ☐ Yes 2 StNo Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 21228 United States 517 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1971 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erma A. Pylant Robert J. Meier, Jr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 517 Edmondson Avenue Catonsville, MD Alice L. Meier - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 07/12/2012 Elkridge, MD Meadowridge Mem. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WEEKS a ADULT RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUMBNIG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown ARDIOMYODATHY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28h Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Baltimore, Maryland 21215-0036

124

State

Registrar

29b. Signature and title of certifie

and_manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOOCATON

29c. License number

BALTIMORE, MODIZIZZ9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 201^{Yea} Stanley Morse 10:30 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood and Crumland Farms Frederick Frederick Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 080-22-8248 Davs Hours Director 82 New York 1 ₹ M 2 □ F July 17, 1929 Yrs Usual Residence of Decedent 28a-f show 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral 23a 7401 Willow Road 21702 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner ed Forces? Black, White, etc. ō þ 1 Never Married 2XXMarried XX_{Yes} Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) giene. Elementary/Secondary (0-12) College (1-4 or 5+) IBM Engineer age 1 and 2 should be filed withingent of Health and Mental Hygienent: If item 27 is marked other thy or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Morse Ruth Roman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Department of Health as Important: If item 27 is any injury or other 7401 Willow Road, Frederick, Maryland Nieves Morse - wife 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial 7-7-2012 Frederick, Maryland 4 Donation 5 Other (Specify) Signeture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) second Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Season at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed Yes 2 After this certificate 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Drive 31. Date filed (Month, Day, Year) State 32. Fegistrar's Signature

Registrar

DHMH 17 Rev 06-2011

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2:00 аМ Harry Leonard McMullen June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cecil Laurelwood Care Center E1kton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** ^{Year)} 1926 Days Hours June 15 1X M 2 □ ^{Country)} Ma<u>ryland</u> 217-20-3391 Director 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 946 Principio Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 Married ģ X Yes Yes, Give 1 Yes 2 No Specify White Specify: 3 Divorced 4 Divorced Completed Year or Dates. W.W. II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Henkles & McCoy Elementary/Seconday (0-12) College (1-4 or 5+) Contractors Foreman Seven Years Rising Sun, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Joseph A. McMullen Mary Louisa Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 946 Principio Road, Port Deposit, Maryland 21904 (wife) Evelyn McMullen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 07/02/12 Port Deposit, Maryland 4 Donation 5 Other (Specify) Hopewell Cemetery 21. Signature of Funeral Service Liger 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mhnow disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) ed by the a Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital: Other: 2 🗷 No Certificate: To 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

12+1 VA

ည

31. Date filed (Month, Day, Year) Registrar

126 A 32. Registrar's Signature

7.3.2012

Eleton MD21921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma	-	partment of I		Mental Hygi	ene 20	12 23305	
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of t	Death	2. Date of Death	g. No.	3. Time of Death	
	Physicia Medic	n/	Margaret Keeney Magner				July 6.	Day	10:50 A M	
المرابعة المربعة	Examin		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital			r Location of Death Spring		4c. County of	of Death gomery	
	Funeral Director			(In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	1917	9. Birthplace (State or Foreign Country) DC	
			Usual Residence of Decedent	10.00.7						
ırylanc	ied af	ctor		10c. City, Town or I Hagerst					10d. Inside City Limits 1 ☐ Yes 2 😾 No	
he Ma	or 28a	Dire	Maryland Washington 10e. Street and Number	nagerbe	10f. Zip Code		11	Og. Citizen of W		
with 1	s 23a ust b	Funeral Director	138 Fairground Avenue		21740)		USA		
Z1Z15-0036 within 72 hours after death	th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes 2 ☑ New Year or Dates.		. Was Decedent of In If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, Puert		Black	- American Indian, s, White, etc. White	
2-0	"natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	i (Giv	edent's Usual Occup e kind of work done	during most of wor	king	16b. Kind of Business Industry		
	r than	Completed	Elementary/Seconday (0-12) College (1-4 or 5+	}	DO NOT use retired, ancial Ana			Federa	al Government	
ם א ש	l Hygi l other vent, 1	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, M			
\$ 5	Menta narked natic e	욘	Elmer William Keeney			Nellie	Blanche	Turner		
	of Health and litem 27 is n other traum		19a. Informant's Name/Relationship (Type, Print) Charles T. Pratt / Executor	ı	iling Address (Street 70 Lakesho					
Saltimore, permit. Page 1 and	ent of He nt; If iten ry or oth		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cr	position (Name of ematory or other pla Vashingtor	ce) 1 Cemeter	July 10		City or Town, State	
	Department of I Important; If its any injury or of once.		21. Signature of Funeral Service Licensee				- 4014	delphi.	Inc. Spring, MD 20901	
H			23a. Part 1. Inter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.						Approximate	
	ysician/	8.0	Immediate Cause (Final disease or condition	tion					Interval Between Onset and Death	
	Medical xaminer		resulting in death) Due to (or as a Hyperna	consequence of):						
D.	sit	Examiner	Sequentially list conditions.	consequence of):						
certificate be executed	physician and s the burid transit	al Exa	that initiated events	consequence of):			,			
oate be	physic the bu	edical	d							
BOX 68/ death certific	been signed by the attending should be detached for use as	Physician/M	1 Yes 2X No 4 Pregnant at 1	Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date Mon	e of delivery th Day Year	
that the	d by th		9 Unknown Part II. Other significant conditions contributing to death but	t not resulting in the	underlying cause g	iven in Part I.	23e. Did tob	acco use contrib	bute to the cause of death?	
10	en signe ould be c	ted by	Dementia, Failure to Thrive						3 ☐ Probably 4X Unknown	
DIVISION OT VITAI KECOLDS, tal or Attending Physician: The law requires	certificate has be lirector, page 2 sh	Completed by		-			24a. Was an autopsy perform	pr ned? de	fere autopsy findings available rior to completion of cause of eath?	
da	sertifica ector, I	Be	25. Was case referred to medical examiner? Hospital:			lace of Death (Che	ck only one)	¥-7-1777		
OT VI	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	ite: To	1 ☐ Yes 2X No 1 IX Inpatier 27. Manner of Death 1 ☐ XNatural 5 ☐ Pending (Month, Day,	nt 2 ER/Outpat 28b. Time Year) injury	of 28c. Injur	4 □ Nursing F ry at	lome 5 Resider 28d. Describe how			
ISION Attendi	ector: A ector: A by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury		M 1 C	Yes 2 No			or Rural Route Number,	
DIV pital or	ours afte eral Dira filled in		29a. Certifier 1 🛣 Certifying Physician: To the best of m		h occurred at the time	a date and place	City or Town,		v on stated	
the Hos	hin 24 he the Fun npleted	Medical	(Check 2 Medical Examiner: On the basis of examiner) only one) 3 Certifying Nurse Practioner: To the basis of examiner.	amination and/or inv	estigation, in my opini e, death occurred at the	ion, death occurred ne time, date and pla	at the time, date and ace, and due to the c	place, and due cause(s) and man	to the cause(s) and manner stated. nner as stated.	
2	٥٩٩٩		29b. Signature and title of certifier	MI	29c. Licens D686		29	July 6	(Month, Day, Year) , 2012	
			30. Name and address of person who complete cause of dea Charu Maheshwary, MD 1500 I	ath (Item 23a) (Type Forest G1	en Road,	Silver S _l	oring, MD	20910		
Œ	Stat Registra		31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar	's Signature	who					

		Plea	se Type or							_			gible.	
	-	For State Registrar	State o	f Marylan		artment <i>tificate</i>			ind IV	lental Hy	gien Reg. I	2	012	23308
		Decedent's Name (First, Middle	, Last)					-		2. Date of De	eath		<u> </u>	3. Time of Death
Physicia Medic		George	Phili	р		Mason				Month 7	1	Day	2012	7:35 P M
Examin		4a. Facility Name (if not institution,		ber)		4b. City, To	own, or Lo	cation of	Death		4		ty of Death	
F		1912 Kipling Dr: 5. Social Security Number	ive 6. Sex	7. Age (In yrs. Ia	est hirthday)	Sa1	isbu:	ry Under 2	4 Hrs.	8. Date of Bir	dh.	Wi	Comic	O place (State or Foreign
Funeral Director		169-18-1314 Usual Residence of Decedent	1 🖾 M 2 □ F	92	Yrs.	Months		lours	Min.	1-15-1	920	7	Cour	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10a. State 10b. County	omico	10c. City	y, Town or Lo	sbury			·					10d, Inside City Limits 1 ☐ Yes 2X☐ No
the M or 28 e noti		10e. Street and Number	SIII CO		Sall	10f. Zip (Code				10g.	Citizen o	f What Cou	ntry?
s 23a nust b	era	1912 Kipling Dr	ive			21801					USA			
death 'item ner m	Completed by Funeral								t of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.					
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in 72 ho e. nan "nat Medica		15. Deceder (Specify only highe Elementary/Seconday (0-12)	(Give	Decedent's Usual Occupation Give kind of work done during most of workin fe. DO NOT use retired)							Business In	dustry		
d with lygien ther th	ا ہ ا	12	1		E1e	ectrical Mechanic 18. Mother's Name (First, I					Civil Se			vice
be file ental F ked of c evel	To B	17. Father's Name (First, Middle, L Carroll	ast)		Maso	n		3. Mother Clar		e (First, Middle,	, Maide	n Sumar		xander
hould ind Me s mar umati		19a. Informant's Name/Relationsh	nip (Type, Print)		T					l Route Numbe	er, City	or Town,		
id 2 st salth a n 27 is er tra		George T. Mason	n - Son		1912	Kipli	ng D	rive	, Sa	lisbur	v .	Marv	land	21801
je 1 ar t of He If iter or oth		20a. Method of Disposition 1	3 Removal from	State C	lace of Dispo emetery, cren	natory or oth	er place)	***		Date	20c.	Location	n - City or To	own, State
it. Pag rtmen rtant: njury		4 Donation 5 Other (S		Brio	ck Fri				•	-2012				aryland
permit Depar Impor any in		21. Signature of Funeral Service	eu Du	then		Name and				Sounds				land 21804
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	7	caused the death								<u> </u>	11017	Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	Thy one cause on ca							w des		Le		Onset and Death
Medical Examiner		resulting in death)	Due to	or as a consequ										
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cate be physic the b	edic		d		··- ···									
certific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant		come of pregna		15						23d. E	ate of deliv	rery
e death the atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 ∐ Feta nant at time of c nown		Ectopic produced of the control of t						N	onth	Day Year
that th ned by detac	by Ph	Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying ca	use given	in Part 1.		23e. Did t	obacc	o use cor	ntribute to t	he cause of death?
quires en sign uld be	ed b	matery	17 M	ostate (Elmeh]				1 🗆	Yes	2 110	3 🗌 Pro	bably 4 🗆 Unknown
aw rec las be	Completed		0 1							24a. Was auto	psy		prior to co	psy findings available empletion of cause of
: The I cate h ; page										1 🗆 Yes	2 E		death?	2 🗆 No
sician certifi rector) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		50/0 1		26. Place Other:			100		- 🗆 -		
g Phy er this eral d	e: To	27. Manner of Death	28a. Date	Inpatient 2 of injury th, Day, Year)	28b. Time of		c. Injury at			me 5 Tesi 28d. Describe				/)
ending sath. or: Aftu he fun	ficat	1 Natural 5 Pendin 2 Accident Investig	gation	m, Day, rear)	injury	М	work?	s 2 🗆 I	No					
I or Atta after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	28e, Place	of Injury - At ho ng, etc. (Specify,	me, farm, str	et, factory,	office			28f. Location (City or To			ber or Rura	l Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 bours after death. within 24 bours after death. To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial.	Medical	(Check 2 Medical E		is of examination	and/or inves	tigation, in m	y opinion, o	death occ	curred at	the time, date	and pla	ce, and d	lue to the ca	use(s) and manner stated
To the vithin of the comple	Ž	only one) 3 L Certifying 29b. Signature and title of certifier	icense nu	ımber	1	e, and due to th			nanner as si ed (Month,					
100		Kodh	my ah	lennd	_ Mg	J-6) 15	538	4		٨	JUH 5	- UUL	Y 2, 2012
4		30. Name and address of person	who completed caus	e of death (Item	23a) (Type, F	Print)				A) . C T	/	h-	, n:	enu
Stat	0	31. Date filed (Month, Day, Year)	ENRICH D	egistrar's Signat		· DIVIS	10N C	٠١٠	5	ALISBI	JKY	ly.	D 4	001
Stat Registra		31. Date filed (Month, Day, Year)	2012	me p	1. 190	W								

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Annie Louise Maddox 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center KICOMICO REGIONAL SA6136414 TENINSULA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Funeral Days (Month, Day, Year) 73 Director 216-38-9140 1 □ M 2 🖾 F June 19, 1939 Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 1115 Shawnee Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Yes 2 XNo Yes, Give ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🖾 No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Domestic Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Norman Gale, Sr. Beulah Mills 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 Shawnee Avenue-Salisbury, Maryland 21801 Matthew Maddox/ Husband Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ACremation 3 Removal from State any injury or July 6, 2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service License Salisbury, Maryland 22. Name and Address of Facility Jolley Memorial Chapel - 1213 Jersey Road 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): anding physician and use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ò Month been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe rmed? 2 No 1 Yes 2 No 24 hours after death. Funeral Director: After this certifical etely filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗶 No Other: ဥ 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural work? 1 Yes 2 No 5 Pending Division 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Hospital To the Hosp within 24 hou To the Funer completely fi

Medical

29a. Certifier

(Check

31. Date filed (Month, Day, Year)

05

State Registrar son who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

City or Town, State)

29d. Date signed (Month. Day, Year)

:040 P.M.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

Year

2012

1 Yes 2 KNo

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EDWARD HAVEL NICHOLSON 2012 7:20 P JUNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Months Days Hours **Director** 04/06/192 218-07-4112 91 MARYLAND Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 XNo MD **KENT** WORTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25193 PORTERS GROVE ROAD 21678 UNITED STATES permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

XYes 2 No Black, White, etc ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–46 1 Yes 2 XNo Specify. Specify: WHITE 3 ■ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PLUMBING / ELECTRIC PLUMBER / ELECTRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ OLIVER T. NICHOLSON MARGARET LESAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25193 PORTERS GROVE ROAD WORTON, MARYLAND 21678 JOYCE NICHOLSON / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STILL POND CEMETERY 06/07/2012 STILL POND, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, Keil 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between iset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner The mers Sequentially list conditions cause. Enter Underlying Exami **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes Z No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes Hospital Other: A Ursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Funeral Director; After upleted filled in by the funer 1 Natural 2 Accident 5 Pending injury work? Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print reden

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 20:30PMM Pauline J. Nesbitt June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Rising Sun Calvert Manor Healthcare Center Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours July 19, 1911 Newark, Delaware **Director** 1 □ M 2 🛣 F 221-03-1404 100 Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Ceci1 Rising Sun 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21911 1881 Telegraph Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2XXXNo Specify: 3 ₩ Widowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Banking <u>dministrative Assistant</u> other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hazel Biddle Chester Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is
any injury or other trau P.O. Box 222, Elkton, Maryland 21921 Robert Powell / Godson 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Be North Hast Cemetery Methodist Cemetery July 5,2012 North East, Maryland Donation 5 🗌 Other (Spenty) f-Pungal S-rvio 22. Name and Address of Facility Crouch Funeral Home, P.A. 21. Signa 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year ed by the a 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 N 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗀 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7.2.2012. Doo23322. achder 5 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S Sachdev MD 126 A, E High ST ELKTON MD21921.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ $J_{\mathbf{u}}^{Menth}$ 7, 2012 3:55 P M Lieu Van Nguyen Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
 Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Jan. 10, Year) 1911 Days Hours 627-34-4383 **Director** 1 🖾 M 2 🗆 F Vietnam 101 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Vietnam Funeral 20903 1123 Cresthaven Drive death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried 1 Yes If Yes, Giv Completed by Maryland 21215-0036 72 hours after 1 Yes 2 No Specify Specify: Asian and Mental Hygiene. 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Small Business Owner other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Tan Thi Dang Hoat Van Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 9712 Hedin Drive, Silver Spring, MD 20903 Maria N. Do / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 K Removal from State July 12, 2012 Houston, TX 4 Donation 5 Other (Specify) Forest Park Cemetery 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Signature of Funeral Service Licensee Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between
Onset and Death
1 Day Immediate Cause (Final Physician/ Ruptured Abdominal Aortic Aneurysm Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the burig Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Tes ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 X Natural Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after death.

To the Funeral Director: After this

29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

D54486

2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huyanh That Ton, MD 7505 New Hampshire Avenue Ste. 310, Takoma Park, MD 20912

State Registrar

edical

31. Date filed (Month, Day, Year) **JUL 09 2012**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

τιο Επι	z Naeci		1- For State Registrar	Sta	ate of Maryland		artment of <i>rtificat</i> e <i>of</i>			a Ment	aı Hyg		eg. No.	201	2 233
	Physici I Exam		1. Decedent's Name Fritz		_{,Last)} Naecker		-			-	- 1	Date of Dear	Day	Year	3. Time of Death 1714 hrs
none,	LAUIII				n, give street and numbe	r)		4b. City,	Town, or	Location of		July 4, 20		County of Deat	
			Montgomen					Olne		,				ontgomery	
	uneral irector		5. Social Security N	378	6. Sex 7. A	ge (In yrs.	last birthday) Yrs.	Month	der 1 Year hs Days		Min.	B. Date of Bir	`	Forei	rthplace (State or gn Suntry) Shington, D(
	any		Usual Residence of 10a. State	Decedent 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City	, Town or Locati	on		_					10d. Inside City Limits
7	MQ .T	٦c	MD	M	ontgomery		Silver	Spr	ing						1 Yes 2 No
Maryla	28a-f	Director	10e. Street and Nur					10f. Zir				11		en of What Cou	ntry?
4	s 23a or 28a-f shov notified at once.		2904 Nor	th Lei	sure World				2090		:-2 / 5	t. Vac as No	US		inan Indian Disak
eath w	items items	uneral	Marital Status Never Marrie	ed 2 Ma	rried Armed Forces	?					Puerto Ric	fy Yes or No can, etc.)	_ '	White, etc.	ican Indian, Black,
after d	all, or	ш.	3 Widowed 4 X Divorced If Yes, Give Year or Dates:									Specify: White			
d strod	'natur Exami				ify only highest grade co		16a. Decedent during mo				ind of work use retired		16b. Ki	nd of Business/	Industry
more, MD 21215-0036 Passes I and 2 should be filed within 72 hours after death with the Manufand	pount. Tages rang sucuru or muni rango portanti of fealth and Mental Hygiene. Importanti of item 27 is marked other than "nai injury or other traumatic event, the Medical Exa	Completed	Elementary/Seco	ondary (U-12)	College (1-4 or	5+)	Lith	ogra	ph P	rinti	ing			Own Bu	ısiness
215-0036	Hygier other he M		17. Father's Name (,				1			rst, Middle, M			
2121	dental narked event,	Be	Samuel 0				10h Mailing	Addrass	s (Stroot			a Lee		y or Town, State	Zin Codo)
MD 2	27 is number	2			er/Sister		1.0							20833	s, Zip Code)
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imo	nent of			Other Sp		late	ropolit	an C	rema	tory		012		exandria	
Baltimore,	Departu Import njury		21. Signature of Fur				22. N F r	ame and anci	Address S J.	of Facility Co1	lins	Funer	al H	lome Inc	2.
	/sician	3 1	23a. Part Enter th	e disease, or o	complications that cause	the death	500 n. Do not enter th	Uni e mode	vers of dying,	<u>ity P</u> such as ca	31vd . Irdiac or re	W., S spiratory arre	<u>ilve</u> est, shoc	er Sprin k, orheart	Approximate Interval
~_ IN	ledical aminer		failure. List onl Immediate Cause (I or condition resulting	y one cause o Final disease	on each line. a. Multiple Gunsh Due to (or as a con-	ot Wour	nds								Between Onset and Death
			Sequentially list cor		b										
		nine	if any, leading to im cause. Enter Unde (Disease or injury the	rlying Cause	Due to (or as a con-	sequence o	of):								A.
7	nsit _d	Examiner	events resulting in		Due to (or as a cond	sequence o	of):								
exedii	ysician and burial - tra	ledical	UNPENDED		AMENDED										
Box 68760,	physic the bur		IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, outcome	ome of preg				7				Date of deliver	
K 68	attending phy for use as the	Physician/N	past 12 months	?	1 Live birth Pregnant a	t time of de		al death ner (S <i>p</i> e	3 ∟ ecify)	Ectopic	pregnancy		ļ	Month [Day Year
Bo)	the att	hysi		lo 9 Unkr	9 unknown										
Division of Vital Records, P.O. Box 68760, the Honital or Attending Physician. The law requires that the death certificate he executed	signed by	Š	Part II. Other signif	ficant conditie	ons contributing to dea	th but not r	esulting in the u	nderlying	g cause gi	iven in Par	t I.				the cause of death? pably 4 Unknown
of Vital Records,	as been should	Completed										24a. Was a autop:	sy	prior to d	topsy findings available completion of cause of
Rec.	cate hz	E										perfor		death? 1 ✓ Ye	es 2 No
ici it	s certificate rector, page	Be	25. Was case referr examiner?		Hospital:	ant 2 . 4	ER/Outpatient			<u> </u>	Check only Nursing H		Residen	ce 6 Other	
of V	After this	년 :	1 ✓ Yes 27. Manner of Deat	No No	i lipat		28b. Time of In			y at Work?		d. Describe h			
On	eath. or: At the fur	ţį	1 Natural 2 Accident	5 Pendi	28a. Date of In Jul 4, 2012 igation	Year)	1700 hrs		1 Y	es 2 🗸 I	_{No} Su	bject shot	by po	lice	
Division	within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide		not be 28e. Place of I		ome, farm, stree	t, factory	, office bu	uilding, etc.					ral Route Number, City
	within 24 hours To the Funeral completely filled		4 Homicide 29a. Certifier		ysician: To the best of r			ed at the	etime dat	te and plac					
To the I	within 24 h To the Fur completely	Medical	(Check only one) 2	Medical Exan	niner:On the basis of example and manner stated	amination a	and/or investigati	on, in my	y opinion,	death occ	urred at th	e time, date a	and plac	e, and due to th	e cause(s)
£	10	Μe	29b. Signature and	title of certifier				290	c. License					ate signed (Mo	nth, Day, Year)
			and and	bC					O.C.N	Л. Е.			July	5, 2012	
			30. Name and addre		who completed cause of . Assistant Med	•		W. Ba	ltimore	Street,	Baltimor	e, MD 21	223		
	S Regis	tate	31. Date filed (Mont.	h, Day Year)	2. Registr	ar's Signati	Jest .	1.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ Year \mathbf{a}_{M} O'Connell 4, Monica Μ. 6:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MN Funeral 1 □ M 2 □X Days (Month, Day, Year) Oct. 21, 1927 Hours Min. Months 469-28-8053 Director 84 Usual Residence of Decedent 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ð 2 No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) per it. Page 1 and 2 should e filed within Det artment of Health and Mental Hygiene. Important: If item 27 is marked other that an injury or other traumatic event, the Manning one each. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Librarian Public Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O'Connell ည Emma Noesen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Feistritzer/POA 10661 Montrose Avenue, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 5 2012 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA of Funeral Service Licer Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the build-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): \mathcal{N} ነ $\mathcal{C}\mathcal{H}$ \mathcal{O} $\mathcal{C}\mathcal{O}$ ሃነት \mathcal{C} Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed; 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 7 10 Certificate: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending injury 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

NONICA

State Registrar

4

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SH

06 2012

29c. License number

29d. Date signed (Month, Day, Year)

20

12-05109 Virginia E. Prince

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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giilla E. i iiile		1-For State Certificate of Department of Pierres Certificate of Pierres Certifica		Reg.	No.	
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exam	iner	VIRGINIA ELIZABETH PRINCE		July 7, 2012		2110 hrs
			ity, Town, or Location of Death altimore	1	4c. County of Death	
Funeral				s. 8. Date of Birth(MM/DD/YYYY) 9. Birth	place (State or
Director		M F	onths Days Hours Min	i. '	Foreign	
		214-84-0608 1 M 2 X F 48 Yrs. Usual Residence of Decedent		08/14/1	963 [MAK]	LEAND
' any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show any d at ence.	ō	MD KENT CHESTERTOWN				1 Yes 2 No
Mary r 28a- ed at	Director	10e. Street and Number 10f	. Zip Code	10g.	Citizen of What Count	ry?
ith the 23a o	al D		1620 cedent of Hispanic Origin? (Sp		ITED STATES	
ath w items	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, sp	pecify Cuban, Mexican, Puerto		14. Race - America White, etc.	an Indian, Black,
fter de I", or		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes	2 X No specify:		Specify: WHIT	Έ
ours a atura	d by		sual Occupation (Give kind of vitworking life, DO NOT use reti		6b. Kind of Business/Inc	dustry
16 n 72 h	lete	Elementary/Secondary (0-12) College (1-4 or 5+)				
withii withii giene.	Completed	12 2 STATE TI		(First, Middle, Mai	LAW ENFORCE	MENT
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C				·	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health and Montal Hygiene. Inter of Health and Montal Hygiene "natural", or items 23a or 28a-f she mat. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	ress (Street and Number or F	Rural Route Numbe	r, City or Town, State, 2	Zip Code)
MD 1d 2 sho alth and m 27 is		CHARLES PRINCE / HUSBAND 8249 MT	. PLEASANT PLA	NTATION_I	LN. CHESTER	TOWN, MD
or Heal		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or other pl		Date 2	Oc. Location - City or To	own, State
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		4 Oonation 5 Other Specify: CHESAPEAKE	CREMATION 07/	13/2012	STEVENSVILL	E, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Helant and Mental Hygiewie Important: If item 77 is marked other than "matural", or items 23a or 28a-f shou injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee FELL	and Address of Facility OWS, HELFENBEI	N & NEWNA	AM FUNERAL	HOME, P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	SPEER ROAD CHE ode of dying, such as cardiac of			Approximate Interval
/Medical	•	failure. List only one cause on each line. Immediate Cause (Final disease a. Myocardial Infarction				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	-	Sequentially list conditions, if any, leading to immediate b. Coronary Artery Thrombosis Due to (or as a consequence of):				-
	를	cause. Enter Underlying Cause				
led nsit	Examiner	events resulting in death) Last Due to (or as a consequence of): d.			1	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDEO				
'60, ate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Oate of delivery	
687 certific ading 1	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal de	_	ancy	Month Da	y Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (3	Specify)			- L
that the de ned by the detached f		Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
Division of Vital Records, P.O. and or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by			1 Yes	2 No 3 Probal	oly 4 🗹 Unknown
cords, law requir has been s	ete			24a. Was an autopsy		psy findings available apletion of cause of
Reco	Completed			performe		2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check			
Physic rathis	힏	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury	DOA Other Nursin	g Home 5 Res	sidence 6 Other:	
n of ading Pl th. : After e funeral	io ::	1 V Natural 5 Pending	1 Yes 2 No	20d. Describe now	injury occurred	
isio	<u>icat</u>	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fac		28f. Location (Stre	et and Number or Rura	Route Number, City
Div ital or urs aft ral Di	Certification	3 Suicide 6 Could not be determined (Specify)		or Town, State	3)	
Division of To the Bospital or Attending Ph within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	·			
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		9d, Date signed (Month	n, Day, Year)
20		Mefler Brass G. MIN	O.C.M.E.		uly 8, 2012	
Rm		 Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Ba 	ıltimore Street, Baltimo	re, MD 21223		
	tate	31. Date filed (Month, Da War) 4 0 00 39. Register's Signature	a Mary			
Regis		JUL 1 2012 Commen p. 150	The same of the sa			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First_Middle, Last) 3. Time of Death Month Physician/ 7. 2012 10:15 a.M July Charley John Page Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 23989 Page Lane Hollywood 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Davs Hours Min. Director 220-16-8519 1 🛛 M 2 □ F 01/25/1927 85 New York Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location Director 1 Yes 2 No St. Mary's Maryland | Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be n Funeral United States 20636 23989 Page Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status the Medical Examiner Armed Forces?

1 XYes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: "natural", White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 12 Electrician of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မှ Reba Dorcas Feathers Charles Frances Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23989 Page Lane, Hollywood, Maryland 20636 Betty Page/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, ō Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 07/12/2012 Hollywood, Maryland Joy Chapel Cemetery Signal re of Juneau Service ansee

Michele Brinsfield M01652 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart Physician/ disease or condition Medical resulting in death) **Examiner** ritica Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Month Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Abrillation, MINGI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 N 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ${}_4 \square$ Nursing Home ${}_5 igoditimes {}^4 \square$ Residence ${}_6 \square$ Other (Specify) 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending s after death. 1 Yes 2 No filled in by the Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00055682 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) io+bme 23140 Moakley Street, Leonardtown, MD Wilkinson M.D. 20650 Thomas M.

State Registrar JUL 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ July 8, 2:40 a.M Mae Ptaszynski Medical Sharon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Min Director 372-68-7764 1 ... M 2 X F 56 11/11/1955 Michigan Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45415 Tippett Road 20636 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willis Burke Julia McCardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45415 Tippett Road, Hollywood, MD Stanley Ptaszynski/Husband <u> 20636</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre07/11/2012 | Charlotte Hall, MD Edward N. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. V/21 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any Ladin, to immediate cause. Enter Underlying Due to or as a conse uence of Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Day Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an has perforn 24 hours after death.

Funeral Director: After this certificate I Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 No Accident Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check within 2 To the F only one) ture and title of certific 29b, Sig 29c. License number 29d. Date signed (Month, Day, Year) 428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 pml State

Registrar

DHMH 17 Rev 06-2011

William

D

Boyd,

II

M.D

Registrar's Signat

25365 Point Lookout Road, Leonardtown, MD

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend #2 per verbal/DVR G929 / Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 | | 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 PATTERSON 650 PM HETCY CHARD 54n Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ti. wicomico 1564x mo Rehab + Myrsing If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs ast birthday) **Funeral** 1 € M 2 □ F Months Days Hours Min Country) Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Patter S2/215-0036 Baltimore, Maryland 21/215-0036 1 Yes 2 No MU TYASKIN WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 R65 WHITEHAUEN 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FAMER AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARRY A. PATTERSON INENE CARVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATTERSON 322 WHITE HAVEN RD TUASKIN mD DRES **WYXX** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State AUSBURYGEMAtory SALBBURY IND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility 21. Signature of Funeral Service License 1 tenspoerd & MESSICK-funeral mas416 BLOWN IND 21814 Home ROBOXGI 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Part 1. Efter the disease, or complications that could shock, or heart failure. List only one cause on each line ediate Cause (Final Immediate Cause (Final Onset and Feath Priysician/ enmonia Noctes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Monie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Day Year been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy perform death? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA AND Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ë 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Certificat Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbur 1VIC recholas odulia 31. Date filed (Month, Day, Year, gistrar's Signature 28 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death 8:56 A. Day 2012 Year Month Physician/ 30, Evelyn Elizabeth Pitts June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-24-2253 **Director** 1 □ M 2 🔀 F 86 5/1/1926 North Carolina ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Yes 2 No D.C Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 Jefferson Street, N.W. 20011 U.S.A. items · death v 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify Black Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry oe filed with. ⁴al Hygiene. `ar **than "r** (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>12th grade</u> <u>Homemaker</u> Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Willie E. Dent, Sr. Mary Cooke Department of Health and Important: If item 27 is n any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loyce Pitts (Daughter) 3317 East Glen Reed Court Lanham, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Harmony Mem. Park 7/7/2012 Landover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licens 4217 9th Street, N.W. Washington, D.C.2001 art 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final CARDIAC ARRHY THMIA Physician/ FATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) e attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END STAGE RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed should HYPER TENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy page 2 performed? Yes 2 No ON OESTIVE 1 Yes 2 No If or Attending Physician: after death.

Director: After this certifications 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending work? 2 🗌 No the Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Hospital Medical 1 🌋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, mel

HOSPITAL

CHEVERLY MS. 20785

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year July Physician/ Day Lawrence B. Pendergraph 8 5:30A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** May3, 1930 Mir 579-34-5715 82 North Carolina 1 X M 2 □ F Director 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Maryland Prince George's Beltsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 United States 11604 35th Place or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 105 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify rr Yes, Give Year or Dates.1950-1952 Specify: "natural", 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Painter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, marked Mental Mata Hill Frank Pendergraph . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 11604 35th Place Beltsville, Maryland 20705 Mary Pendergraph -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 Burial 2 Cremation 3 Removal from State 7/13/2012 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonara do Vi∘Borgwardt Funeral Home, PA Nonald VISon 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Intracranial Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No eral Director: After this certificate has filled in by the funeral director, page 2 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) July 8, 2012 D65953

DHMH 17 Rev 06-2011

Registrar

Adaku Onukogu,

M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

ho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Martha Barton Q30 F M QUIMS 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **OUEEN ANNES** 648 DEL RHODES AVENUE OUEENSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min Director 216-38-7624 1 🗆 M 2 🕱 F 89 NOV.3,1922 MARYLAND Usual Residence of Decedent shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **OUEENSTOWN OUEEN ANNE'S** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21658 USA 648 DEL RHODES AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) LIBRARIAN T.TBRARY permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BESSIE EWING HARRY T. BARTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 HOPE ROAD, CENTREVILLE, MD 21617 ALAN LEE QUIMBY/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State JULY 10, WOODLAWN MEMORIAL PARK EASTON, MD 4 Donation 5 Other (Specify) Funeral Service/Li Signature FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 408 S. LIBERTY ST., CENTREVILLE, MD 2161 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician entema disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Due to (or as a consequence of). Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician the doruge as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2. No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? 1 Yes 2 No 1 Yes 2, No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No safter death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year, 201 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 AMAROLU MD 2003 Rhal 31. Date filed (Month, Pay 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ ROBERT JOSEPH REINBOLD JUNE 28 5:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 102 POWELL STREET QUEEN ANNE'S CENTREVILLE Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Director 203-18-6088 87 1 🛛 M 2 □ F 06/13/1925 PENNSYLVANIA Usual Residence of Decedent or 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No QUEEN ANNE'S MD CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 102 POWELL ST. USA 21617 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 10. Black, White, etc. 1 Never Married 2 X Married Completed by 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other th DESIGN ENGINEER ELECTRONICS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOSEPH REINBOLD MARGARET S. SWEENY other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE S. REINBOLD/WIFE 102 POWELL ST. CENTREVILLE, MD 21617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition *(Name of* CHE/SAPEAKEP*ry* CREMATE ON 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State 06/28/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Funeral Service License FELTOWSAddreelPerbein & Newnam Funeral Home, P.A. 130 SPEER RD. CHESTERTOWN, MD 21620 Part 1. Enter the disease, or compl shock, or heart failure. List only one , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician nile disease or condition resulting in death) mentre years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. to Underlyling Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 15 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) + 8221 leal 31. Date filed (Month,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Ju1yCarlos Alberto Ricagno рм 10:50 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 18723 Olney Mill Road 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year, 579-54-5671 1 🖾 M 2 🗆 F April 7, 1938 Argentina 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD 1 Yes 2 No Montgomery 01ney 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 18723 Olney Mill Road 20832 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 1 No Specify:White 1 ☐ Yes 2 A No Specify. If Yes, Give 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner and Operator Building Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Italo A. Ricagno Otilia V. Labourt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Ricagno/Wife 18723 Olney Mill Road, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 6, July 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 2012 21. Signature of Funeral Service Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician, Medical Examiner

permit. Page 1
Department of
Important: If it
any Injury or o

Physician/

Examiner

Funeral

Director

28a-f shov

1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shoother traumatic event, the Medical Examiner must be retified at

Baltimore, Maryland 21215-0036

Medical

Director

Funeral

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Completed

Be

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attending physician and if for use as the burial-transit Physician/Medical been signed by the should be detached Be Completed by page 2 s To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to Certificate: To

Paul Andrew Bannen, MD

09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

resulting in death)	a. Metastatic Non-Small Cell Lung Cancer Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Non-Small Cell Lun; Cancer Due to (or as a consequence of): Due to (or as a consequence of):	9 vrs.						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of de Month	alivery Day Year					
Part II. Other significant conditions c	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to						
		autopsy prior to performed? death?	topsy findings available completion of cause of s					
25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)						
1 ☐ Yes 2 ^X ☐ No	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 4 ☐ Nursing Ho	ome 5 🛭 Residence 6 🗆 Other (Spec	cifv)					
27, Manner of Death 1 Natural 5 Pending Could not be a cou	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M I □ Yes 2 □ No	28d. Describe how injury occurred						

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MD060335

Prince Philip Drive, Olney, MD 20832

29d. Date signed (Month, Day, Year) July 6, 2012

DHMH 17 Rev 06-2011

State

Registrar

18111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:20 A M Physician/ MARY ELIZABETH BROWN STRAUB JULY 8, 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** KENT CHESTERTOWN 103 RIVERSIDE TERRACE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 5. Social Security Number Days Hours **Funeral** 01/06/1916 WASHINGTON, D.C. 1 M 2 X F 96 Director 557<u>-07-9680</u> Usual Residence of Decedent 10d. Inside City Limits Show 10c. City, Town or Location 10b. County 10a, State bartment of Health and Mental Hygiene. oorbart: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at with the Maryland Director 1 X Yes 2 No CHESTERTOWN KENT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral UNITED STATES 103 RIVERSIDE TERRACE 21620 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner my once. 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 2 XNo 1 Yes Completed by 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 WHITE 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PETROLEUM **OFFICER** 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) မ WAUNETAH TANKERSLEY THOMAS RICHARD BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 200 NORTH WATER STREET CHESTERTOWN, MARYLAND 21620 SUZANNE MOORE / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION 07/09/2012 STEVENSVILLE, MARYLAND 4 Donation 5 Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Signature of Funeral Service Licenses 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 ul of Approximate Interval Between Onset and Death arions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, o comple shock, or heart failure. List only one Immediate Cause (Final 400VS Alzhermers Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Month Day in the past 12 months?

1 Yes 2 No Pregnant at time of death 4 Pregnant a ias been signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hypothyroid, Hx Multiple TIA'S 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate has performed? 2 🗆 No page 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 1 Yes 2 No P 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: Natural Natural 5 Pending death. Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu To the Hospital

> State Registrar

Medical

29a. Certifier

29b. Signature

(Check only one

30. Name and addre

31. Date filed (Month 0 1

completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0050996

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LOWELL RAY SHAW 2012 JULY 1:57 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF QUEEN ANNE'S CENTREVILLE QUEEN ANNE'S Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Min. **Director** 233-68-1859 1 🗶 M 2 🗆 F 70 03/20/1942 WEST VIRGINIA 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 X No QUEEN ANNE'S CHESTERTOWN MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 HEATH ROAD 21620 UNITED STATES Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ 12 TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked ot ည GUY R. SHAW OPAL BEALE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL SHAW / WIFE 127 HEATH ROAD CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o once, Department of 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 07/02/2012 STEVENSVILLE, MARYLAND Signature of Feneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND or complecations to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one caus Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ClioBlanana Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death signed by the a Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE A Other Hospital: 1 Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 163747 address of person who completed cause of death (Item 23a) (Type, Print) 12

State Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month

Contreville

2540

strar's Signature

CENTREVILLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar		TVICE YICE	Cer	tificate of l	Death	ivioinai i iy	Reg. No.	2012	23321
П	Physicia	an/	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
ليدسم	Medic	cal	Mary Nell Svit				T		Ju1y_	8	2012	7:20A ^M
	Examir	ier	4a. Facility Name (if not institution,		er)			r Location of Death	٦		County of Death	
- American	Funeral		13964 Oaks Roa 5. Social Security Number		Age (In yrs. las	t birthday)	If Under 1 Year	esville I If Under 24 Hrs.	8. Date of Birl		Charles 9, Birthp	lace (State or Foreign
	Director		579-56-5038	1 □ M 2 💢 F	7	0 Yrs.	Months Days	Hours Min.	(Month, Da		Count	ry)
	d ow		Usual Residence of Decedent 10a. State 10b. County		10- 04	T 1			11/04/	1941		gfield, MO
	rylan I-f sh ied a	양	MD Char	1		Town or Loc	sville				10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number	Tes		nugne	10f. Zip Code			10a Citiz	en of What Count	
	with the 23a c	Funeral	13964 Oaks Ro	ad			2063	7		USA		
	tems er mu	Fun	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. V		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		4. Race - America	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			Yes, specify Cuba		o Hican, etc.)	S	Black, White, e pecify: Whit	
21215-0036	hours natura dical E	Completed	15. Deceder	Year or Date		16a. Deced	lent's Usual Occup	pation		16b. Kin	d of Business/Ind	ustry
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21	d with tygier ther t nt, th	Be C	12		·	Во	okkeeper				ste Disp	osal
anc	ntal F red of	To B	17. Father's Name (First, Middle, L	,				18. Mother's Nan		Maiden Su	urname)	
Z	ould to		George Ganey 19a. Informant's Name/Relationsh			10h Mailin	a Address /Circot	Mary and Number or Rui		. City on T	num Ctata Zia C	a dat
M	12 sh alth ar 27 is r trau		Ronald Gene Svi		bre		-	Hughe)de)
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<u>m</u>	Page nent c ant: If ury or		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S	3 □ Removal from St pecify)	Brins		natory or other place 1–Echo1s	Crem 07/	11/2012	Char	lotte Ha	.11. MD
Baltimore, Maryland	permit. Departr Importa any inju		21. Signature of Funeral Service L			22	. Name and Addres	ss of Facility Br	insfield	l-Ech	ols F.H.	, P.A.
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			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that cau nly one cause on eac	sed the death. line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
سفنتر	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a5	200	/ -	Ce	\sim (e	<u></u>			Onset and Death
	Examiner		Todalang in doaling	Due to (or	as a consequer	nce of):						
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequer	nce of):						
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	ian ar		resulting in death) Last	Due to (or	as a consequer	nce of):						
8760	tificate be executed ng physician and as the burial-transit	Medical	,	d								
687	# 50 B		IF FEMALE:	23c. If yes, outcor	me of pregnanc	ev.						
Вох	The law requires that the death cert ate has been signed by the attendir page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No	1 Live Bir	th 2 Fetal ont at time of dea	death 3	Ectopic pregnand Other (specify)	У		23	3d. Date of deliver Month	Day Year
B	the de	hysi	9 Unknown	g □ Unknow								
P.O.	that ined be det	by P	Part II. Other significant condition	ns contributing to deat	h but not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use	e contribute to the	cause of death?
ds,	quires en sig ould b	per							1 🗆 '	∕es 2□	No 3 Proba	ably 4 Hunknown
Records,	< 0001	Completed							24a. Was a			sy findings available
		Con							perfo	med?	death?	2 □ No
<u>ra</u>	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Chec	- 75			
<u> </u>	Phys this c	<u>ا</u>	1 Yes 2 No	1 Inp	patient 2 EF	R/Outpatien		4 ∐ Nursing H			Other (Specify)	
0 _	ding f th. After funer	cate	1 Atural 5 Pending	g (Month,	Day, Year)	injury	28c. Injury work M 1		28d. Describe h	ow injury o	occurred	
Sio	or Attending Physician: after death. Director: After this certific I in by the funeral director.	Certificate:	2 Ascident Investig 3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place of	Injury - At home	e, farm, stre	et, factory, office	100 1 110	28f. Location (S	treet and N	Number or Rural F	Route Number,
Division of Vital	tal or rs afte al Dire		7 E Homoldo delemin	building,	etc. (Specify)				City or Tow	n, State)		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check 2 Medical E	Physician: To the best xaminer: On the basis of	of examination a	nd/or investi	gation, in my opinio	on, death occurred a	at the time, date a	nd place, a	nd due to the caus	se(s) and manner stated.
	o the	Š	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner: To	the best of my	knowledge,	death occurred at the 29c. License				and manner as sta signed (Month, Da	
	- 5 F O		K	talta			D>	F35) [-9-11	-,, , , , , , , , , , , , , , , , , , ,
1	Same		30. Name and address of person v				rint) (Tisl	narim	math	wr	101	(0)
17)()` Stat	0	31. Date filed (Month, Day, Year)	DOVIS 3. Regi	strar's Signature	ad	W.	a 100	YJ	ーン	206	105
	Registra		JUL 122	2012 Cen	N B.	par	KN					

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Ruby Simpers 20ľ2 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Nursing Center E1kton Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**XX** nth, Day Year 928 Months Days Hours 235-38-8269 West Virginia Director 84 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked of ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notitied at any injury or other traumatic event, the Medical Examiner must be notitied as 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 425 Red Toad Road 21901 United States 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?.

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kennis Dameron Pricey Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Howard W. Simpers / Spouse</u> 425 Red Toad Road, North East, Maryland 20b. Place of Disposition (Name of Northernastation of Methodist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East, Maryland 21. Signature 22. Name and Address of Facility Crouch Funeral Home, P.A. South Main Street North East Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) physician the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 🗌 No Yes 2 N 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 \square Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No 2 Accident
3 Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0026183 3,20/2

State

Registrar

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30. Name and address of person who

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31. Date filed (Month, Day, Year)

backer

mpleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav 3613 uman 2:55 AM 0005 dward Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F Hours Min. Director 219-56-7067 0*777047*1952 59 Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Harford Havre de Grace MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 702 Pulaski 21078 U.S.A. Highway, Apt. death \ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ö ģ 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Driver Truck Driver other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lois Rowland Howard Schuman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12671 Collinsville Rd., Brogue, PA 17309 <u> Vickev Mevers (Sister)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 6 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury (R.A.Ferris&Co, Inc | 07/5/2012 W.Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. nat vr of Funeral Service Licensee any S.Washington St, Havre de Grace, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or shock, or heart failure. List of Onset and Death Immediate Cause (Final Myeca Physician tarc disease or condition tours Medical resulting in death) Examiner oronal J) 5 ea 52 Sequentially list conditions Examine Due to (or as a conseq 4 no if any, leading to immediate cause. Enter Underlying יושיי or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Year Pregnant at time of death Day signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti 29d, Date signed (Month, Day, Year, 4 9019 30. Name and address ss of person who completed cause of death (Item 23a) (Type, Print) JUION Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 June_ 29 10:12am^M Marie Brigitte Slipher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17622 Topfield Drive Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours Min. **Director** 577-86-9820 1 M 2 X F 55 Nov. 7, 1956 Washington, DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 Yes 2 X No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 17622 Topfield Drive United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates # than "he. The Medical F 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene.

of Health and Mental Hygiene.

fitem 27 is marked other than rother traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Busing Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cecile Gamache Anthony Michael Banusevich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17622 Topfield Drive, Gaithersburg, MD 20877 (Spouse) Paul D. Slipher item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/3/12 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Service Licen 22. Name and Address of Facility Peyol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mocordial in treston disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ASHO Sequentially list conditions, Distributor as a numerous nice of cause. Enter Underlying Cause (Disease or injury B the Hospital or Attending Physician: The law requires that the death certificate be executed Hypelensio that initiated events resulting in death) Last Due to (or as a consequence of) burialthe attending physiciar Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Year Pregnant at time of death 1 ☐ Yes ∠ ∠ g ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 2 No 1 🗌 Yes 2 🔀 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 X Yes 2 □ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, npletely filled in by 4 Homicide determined building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or inventigation in my articles in my articles. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PME Yantel July 2, 2012 D29018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue #104, Silver Spring, MD 20902 Betsy Ballard, M.D.

Registrar

32. Registrar's Signature

08 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Anne Simmons 0658 AM JUL 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctors Community Hospital Lanham . Social Security Number 577–46–9918 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days June 15, 1934 **Director** Washington, DC 1 □ M 2 💢 F 78 Department of Health and Mental Hygiene. Important; If item 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Upper Marlboro 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9590 Crain Highway,#15 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: White 3X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Accounting University of Maryland SIMMONS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Ferry Madeline Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9590 Crain Highway,#15 Upper Marlboro, Md. 20772 Christina Springer -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place
Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 7/5/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald V. Borgwardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Examiner cancer Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed B resulting in death) Last Due to (or as a consequence of) burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of deliven Ectopic pregnancy in the past 12 month 1 Yes 2 No Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pancytopenia Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 Yes 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗆 Yes |@ 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a
To the Funeral C
completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) D65909 of person who completed cause of death (Item 23a) (Type, Print) Good Luck ROAD, LANhAM State 06 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#18perFH. G930.8/8/2012.WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Angela J. Slaughter Physician/ 28 / 201 4:15am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Laurel, M.D 20707 Patuxent River Health and Rehab If Under Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 90 6711⁷1⁷1⁷22 578-36-7067 Washington, D.C Director 1 □ M 2 🕱 F Usual Residence of Decede 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland rector notified Prince George's Laurel Maryland 1x Yes 2 ☐ No ö 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 20707 U.S.A 7700 Cherry Lane #319 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bureau of Engraving and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) & Printing Supervisor 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
- Eleanor Parham မ Jose Perez permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to Elonor 19a. Informant's Name/Relationship (Type, Prilation Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelo P. Harrington, Sr. 8811 Evermore Court Laurel, Maryland 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parklawn Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State July 6, 2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signaure of Funeral Service Lice 22. Name and Address of Facilit Marshall-March Funeral Home - hod 4217 9th Street, N.W. Washington, D.C. 20011 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions Examine r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) pue End Stage Dementia The law requires that the death certificate be executed Due to (or as a consequence of) nding physician buri Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No for Pregnant at time of death Month Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 autopsy page performed? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 😿 No within 24 hours after death.

To the Funeral Director, After this certific completely filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗙 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 🛛 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D71264 1 ms 042812012

State

Registrar

20707

Uzo Unegbu, MD 7350 Van Dusen Road Suite 220 Laurel, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A^{M} Jeannette Sue 10, Turner July 2012 5:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6175 Humpback Whale Waldorf Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗓 F Months Hours Min. (Month, Day, Year) 10 / 12 / 19 3 4 Country) Director 579-42-4352 78 Wash Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Waldorf Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6175 Humpback Whale Ct 20603 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify Specify: 3 ₩ Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other th 12 Office Manager Dental Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winsor Wesley Owens Marv Sue Whittington permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Turner/Son 6175 Humpback Whale Ct., Waldorf, MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro. Crematory 07/11/12 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Raymond Funeral Svc., P.A. M01517 5635 Washington Ave. La Plata MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) NWThi Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed the bunal-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMUNARY RUNIC OBSTRUCTIE DISEARC 1 Yes 2 No 3 Probably 4 Unknown Completed the pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Weight 1055 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 No ပ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 29d. Date signed (Month. Dav. Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

102 PAUL

WALPORF MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HVINKUMAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2, Miroslaw Trawinski 4:56 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director None 1 M 2 □ F March 31, 1956 Poland idence of Decedent 28a-f shov items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2224 Wyoming Ave. N.W. 20008 Poland [] filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner ō Black, White, etc. þ 1 Never Married 2 X Married Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Embassy of Poland Chauffeur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o 2 and 2 should be Jozef Trawinski Joanna Kowalska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Teresa Trawinska (Wife) ul.Wittiga 11/7, Warszawa 03-188 Poland altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or oth Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 7/6/2012 4 Denation Other (Specify) Alexandria, VA Sign Jure of Fur eral Service Lic-see ²² Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, V. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and pro Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical of Vital Records, P.O. Box 68760 use as the 7/2/12 IF FEMALE: 3 Ectopie pregnancy 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Pregnant at time of death Oth Month Day Year Yes 2 No be detached 9 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? miroslaw by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Cawinski Division o 1 Natural 2 Accident injury 10 25 p. M 5 Pending work? 7/1/2012 2 🔽 No noto-cycle Investigation within 24 hours after deat To the Funeral Director: Exampletely filled in by the accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) C=0 Cenal lot parking Wet Medical Certifying Physician: To the best of my knowledge, eath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Dave signed (Month, Day, Year) D72421 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year)

State

Registrar

06 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 ear WILLIAM JESSE WALKER July Physician/ 10:59PM 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Harford Brightview Avondell 9. Birthplace (State or Foreign Country) MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 2/21/1928 Months Hours 84 218-22-8691 Vrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford Bel Air 1 X Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA by Funeral 128 W. Ring Factory Rd., #128 21014 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates.WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Civil Service Management Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hyde Walker Emma Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Morrison/Friend 500 E. Wheel Road, Bel Air, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/12/12 Darlington, Darlington Cem. 21. Signature of Foneral Service License 22. Name and Address of Facility C. Koba Harkins Funeral Home, Inc., Delta, PA Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Dro shelve Immediate Cause (Final metastatic the carcer 20 Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical しなしてのでします。 Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for Day Year 4 Pregnant : g Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dises se actory 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 has page 2 within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 🗌 Yes 2 🗹 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗖 Natural injury 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Kageron, M. 208-C Pleathree Rd, Belair, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

s. Rougierai

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0053720

29d. Date signed (Month, Day, Year)

07109/2012

21015

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Robert Scott Wilkinson, Jr. 2012 0709 P 44 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 27480 Stanton Way Mechanicsville St. Mary's If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min 294-58-7427 1 👿 M 2 🗆 F 55 Yrs 12/28/1956 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland St. Mary's Mechanicsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 27480 Stanton Way 20659 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Construction Superintendent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jane Kuntz Robert Scott Wilkinson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Lynn Wilkinson Wife 27180 Stanton Way Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla Brinsfield-Echols 7/14/12 Charlotte Hall, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral HomePA M00817 Aton C. Echol 30195 Three Notch Road Charlotte Hall, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each ine. Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Ph_si_ian/ Medical Examiner

that the death certificate be P.O. Box 68760

peen

has

certificate

24 hours after death. Funeral Director: After this

within 2 To the F

filled in by the

Medical

29b. Signature and title of certifier

Division of Vital Records,

Hospital or Attending Physician: The law

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

items 23a or ner must be n

Examiner

nan "natural", o Medical Exam

permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other frammet:

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Baltimore, Maryland 21215-0036

9

Director

Funeral

by

Completed

Be

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Examin attending physician for use as the buria Physician/Medical detached signed by n þ Completed page 2 funeral director, Be ပ Certificate:

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

10) eme State

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

40900 Merchants Lane, Suite 205 Leonardtown, MD 20650 Jennifer Schmidt.

1 2 2012

Registrar's Signat

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7/1/2012 1:01 pM ELNORMA WOODS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/26/1935 Trinidad 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify. Black 16b, Kind of Business/Industry Nursing 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11507 Sullnick Way, Gaithersburg, MD 20878 20c. Location - City or Town, State Hanover, MD 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death metastatic Angiosarc 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performe 2 No 1 Yes Yes 2 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D72505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Our Dr Rockville MD 20150 9901 BRIDGIT MUMICARA 31. Date filed (Month) Day, Year) State 06 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Jul. Samuel Francis Arnone ,2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL BALTIMORE 70 WSON **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 01, 1932 217-28-9454 **7**9 Months Days Hours 1 **X** M 2 □ F Director 10a. State 10b. Count 10c. City, Town or Location with the Maryland Director 28a-f Maryland Harford County Joppa SAMUEL HEAMORS 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2306 Dunwood Lane 21085 United States 12. Was Decedent Ever in U.S items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? U.S.

1 Yes 2 No Army , or Black, White, etc. þ 1 Never Married 2 Married Báltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give "natural", 3 🗌 Widowed 4 🗌 Divorced Completed in and Mental Hygiene.
It is marked other than "natural traumatic event, the Medical E. Year or Dates Reace Time 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) **06** Public Schools High School Math Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Arnone t. Page 1 and 2 should be timent of Health and Mentant: If item 27 is marke Lucy Fabri 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Marie (nee Gessley)Arnone 2306 Dunwood Lane Joppa, Maryland 20b. Place of Disposition (Name o Location - City or Town, State (Harford County) Date 1 Burial 2 Peremation 3 Removal from State ò Exars Fureral Chartel and Wednesday permit. Page Department (Important: If any injury or 4 Donation 5 Other (Specify) July 25,2012 Forest Hill, Maryland Cremation Services, Inc. 21. Signatur of Funeral Serv Lice effrey L. Gair, Sr. OSP Peaceful Alternatives Funeral and Cremation Center, P.A. Wy / Wic. #M00677 2325 York Road Timonium, Maryland Part 1. Enter the omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line Immediate Cause (Final Ph, sician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or injury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy nin 24 hours after death.

the Funeral Director; After this certificate performe the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Hospital မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural injury 5 Pending work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

32. Registrar's Signature

ADLER

2 ± 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Frostburg, MD.

White

21085

Approximate Interval Between

Onset and Death

3 MONTHS

Year

Dav

1 ☐ Yes 2 ☐ No

TOWSON MARYLAND 21204

1:22 AM

DHMH 17 Rev 06-2011

Registrar

State

DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23336 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 Physician/ Day Year JIMM IE 24 ARROWOED 12:32 PM WAYLAND Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE VA MEDI CAL CENTER BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Davs Hours July 25, 214-54-7188 62 **Director** 1949 NC Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Middle River MD Baltimore 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21220 USA 15 Glider Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than "n any injury or other traumatic conce. (Give kind of work done during most of working life. DO NOT use retired) All StatePlumbing Elementary/Seconday (0-12) College (1-4 or 5+) 12th HVAC & Heating Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hawkins ္ဝ Linder W. Arrowood Donis A. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Glider Drive Balto. MD 21221 19a. Informant's Name/Relationship (Type, Print) Angelika Arrowood /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bayvirewacrematory 7/26/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Metastatic Carahoma unknown disease or condition 04 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of). resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the sales should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural iniury 5 Pendina work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number NPI: 1265798680 7/21/202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Anubhav

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Records,

Division of Vital

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greene

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Barry Erwin Birch 09:41 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Upper Chesapeake Medical Center 9. Birthplace (State or Foreign Country) Baltimore, Maryland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months 219-42-1826 **Director** 1 **X** M 2 □ F 70 Nov. 04, 1941 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f shov rent, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21084 3612 Woodholme Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Tele - Comunications Insurance is marked other injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Ιđa unk Clarence Birch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gregory Birch (Son) 701 Idlewild Road, Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or other place)
Evans Funeral Chapel
Bel Air 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State July 24, 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Figure Service Licensee Jeffrey R. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
Evans Funeral Chapel & Cremation Services — Bel Air Testeman Perturina (M01543) 3 Newport Drive Forest Hill, Maryland 21050 23a. Part I. There is disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on e. ch line. Approximate Interval Between Immediate Cause (Final Onset and Death 186 Ph_{sician}/ disease or condition resulting in death) Medical **Examiner** -316. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami M800. Due to (or as a consequence of): resulting in death) Last Physician/Medical attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ivision of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 25. Was case referred to edical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:35 PM Physician Evelyn F. Blackert PUT 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAUTIMONE MI AGNES HOCPITAL 8. Date of Birth (Month, Day, Year) Nov 20, 1919 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 💢 F 92 Yrs. 215-07-7285 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the McCical Examiner must be notified at 1 ☐ Yes 2 No Director Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 **USA** 13 Overhill Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Holland Florence Eder Pages 1 and 2 should I nent of Health and Men is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 13 Overhill Road Catonsville, Maryland 21228 Donald Blackert, Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland New Cathedral Cemetery 07/25/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liversee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 Thomas 23a. Part 1. Enter the dise ver, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) HRAUT FAILURE 3 DAYS **Physician** ONGEST /Medical Due to (or as a consequence of): **Examiner** ATT4AL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 DaNo 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð A, war usen 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed or Attending Physician: The this certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00040012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 FREDERICK ROAD, SUITE DOY, CATONSVILLE, MO 2132B TON 32. Registrar's ignatur State Registrar

DHMH 17 Rev 1/2001

SLAKERY

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Michael Eric Blo	Bloom State of Maryland / Department of Health and Mental Hygiene 20 2 3 1- For State Registrar Certificate of Death Reg. No.									12 233	
Physician/ Medic Exami	al	Decedent's Name (First, Middle Michael Eric	B loo m					2. Date of D Month July 19,	Day 2012	Year	3. Time of Death 0715 hrs
		4a. Facility Name (if not institution 5124 Wissioming Road	Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deal 24 Wissioming Road Bethesda					n		ounty of Deat ntgomery	h
Funeral Director		5. Social Security Number		Age (In yrs. last b		If Under 1 Year Months Days	If Under 24Hr Hours Mil	ղ.	Birth (MM/DD/	YYYY) 9. Bi C	rthplace (State or Foreign ountry)
	ŀ	216-04-7840 Usual Residence of Decedent	1 ∑ M 2 F	2				Aug	7 , 1 98.	3 1 1.	Maryland
land -f show any once.	for		tgomery	10c. City, Tow	Beth	esda			10d. Inside City Limit 1 Yes 2 N		
he Mary or 28a	Direc	10e. Street and Number 5124 Wissiomii	no Road			10f. Zip Code 208	16		10g. Citizen of What Country? USA		
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If ten 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	unerai	11. Marital Status 1 Never Married 2 Marital	12. Was Decede		If Yes	Decedent of Hispa , specify Cuban, I	anic Origin? (S Mexican, Puert			Race - Ame White, etc.	rican Indian, Black,
rs after ural", c	by	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	completed) 16a		es 2X No a		vork done		ecify: Wh	
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21215-0036 uld be filed within 7 Mental Hygiene marked other than	e Coi	17 Father's Name (First, Middle, Phillip Bloom	Last)			18	.Mother's Name	, .		ame)	
D 212 should be and Menta 7 is mark:	Phi Hip Bloom Allison Loomis 19a Informant's Name/Relationship (Type, Pnnt) Allison Lucas, Mother 32107 Barn Owl Drive Selbyville, DE										
ore, MD set 1 and 2 sho of Health and If item 27 is her traumati	ŀ	Allison Lucas 20a. Method of Disposition 1 Bunal 2 Cremation		20b. Place		n (Name of cemet	tery,	Date	20c. Loc	ation - City o	r Town, State
Baltimore, cernit. Pages I ar Department of Hee Important: If the injury or other tr	ŀ	4 Donation 5 Other St. 21. Signature of Funeral Service	pecify Censeering among	Metro	o Crem	atory In	Facility	/21/12	Bali	timore	, Maryland
		21. Signature of Funeral Service 23a. Part I. Enter the disease, or	Jyou	Gregor	299	mation S Frederi	ck Roa	d Balt	imore,	Mary1	and 21228
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a Narcotic Due to (or as a co	: (Heroin						rneart	Approximate Interval Between Onset and Death
	_	Sequentially list conditions,	b Due to (or as a co								
	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C								
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क स्र ह	dica	X UNPENDED	AMENDED23	1,27,28a	-f,per	me,g929	7-27-	12 sm			
Division of Vital Records, P.O. Box 68760, To the Hosp ral or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial compilercy filled in by the funeral director, page 2 should be detached for use as the burns.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	e 1 Live birth	come of pregnancy 2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (Specify)						23d. Date of delivery Month Day Year	
res that the d signed by the	含	Part II. Other significant conditi	ons contributing to de	ath but not resultir	ng in the unde	rlying cause giver	n in Part I.		tobacco use res 2 No		the cause of death? bably 4 X Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rape death. 13 Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed							pe	as an topsy rformed? s 2 No		utopsy findings available completion of cause of
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of Vil ing Physi After this	٥	1 X Yes 2 No 27. Manner of Death	28a, Date of I	njury 28t	Outpatient : Time of Inju			ng Home 5	Residence be how injury of		Scene
Sion o Attending r death. rector: Aft by the fund	ation	1 Natural 5 Pend 2 Accident Inves	stigation fd 7- 1	19-12 f	d 7:08	am —	s 2 X No	unkno			
Division To the Hosp zal or Attendenthin 24 hours after death To the Funeral Director:	Certification:	4 Homicide deter	d not be Tmined 28e Place o	Found:			Iding, etc.	28f Location (Street and Number or Rural Route Number, City or Town, State) 5124 Wissioming Rd. Bethesda, MD.			
the Hor hin 24 h the Fur	Medicai ((Oncer only	nysician: To the best of miner: On the basis of e	xamination and/or							
To with To com	Mec	29b Signature and title of certifie	and manner state	od	<u>.</u>	29c. License t			1	e signed (Mo	onth, Day, Year)
		30 Name and address of person	who completed cause of	f death (Item 23a)							
Degano 1		Laron Locke MD. A	ssistant Medical E	xaminer 90	0 W. Baltir	nore Street, B	Baltimore, M	ID 21223			

OCME 2008

State Registrar

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	Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University of Mamland Medical Center Caltinua City							<u> </u>	4c. County			
	Funeral Director		5. Social Security Number 218–86–6389 Usual Residence of Decedent		51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct 14,	y, Year)	Birthplace (State or Foreign Country) Maryland		
	yland f show ed at	ctor	10a. State 10b. County		10c. City, Town or Loc					10d. Inside City Limits		
	or 28a- notifie	Direc	MD Carro. 10e. Street and Number	11	Finksbur	g 10f. Zip Code			10- 0141514	1 🗆 Yes 2 🔯 No		
	th with the ns 23a comust be	Funeral Director	4500 Louisville			21048			USA.	nat Country?		
9036	permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flee Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No I	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🙀 No	n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white		
21215-0036	72 hou in "natu Medica	Completed	15. Decedent's I (Specify only highest gi	rade completed)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)		king	16b. Kind of Bu	siness/Industry		
212	I within ygiene. her tha t, the I		Elementary/Secondary (0-12)	College (1-4 or 5	+) .	ectrician			comme	ommercial		
yland	ld be filec Mental H arked otl atic even	To Be	17. Father's Name (First, Middle, Last) Ronald Bunting 18. Mother's Name (First, Middle, Maiden Surname)							unk		
Baltimore, Maryland	nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (1 Sharon Kaschen	Type, Print) easch – fr	iend 19b. Mailin	g Address (Street a	ille Rd;	ral Boute Number Finksbu	City or Town, St	21.048°		
imore	Page 1 a ment of H tant: If ite ury or oth		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location -	City or Town, State		
Ball	permit Depart Import any inj once,		21. Signat in of Funeral Service Licen	Wado Vre	ctor 22	Name and Addres			•	d MD 21201		
			23a. Part . Enter the disease, or comshock, or heart failure. List only of	pplications that caused	the death. Do not ente					Approximate Interval Between		
P	h sician Medical		Immediate Cause (Final disease or condition resulting in death)		the cancer	Stage IV				Onset and Death		
Set :	Examiner		resulting in deathy	Due to (or as a	consequence of):							
	e it	niner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):							
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	physicials the buri	edical	d									
. Box 68	nat the death certificate be ed by the attending physici detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of Live Birth 4 Pregnant at 9 Unknown	2 🗆 Fetal death 3 📃	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month Day Year			
s, P.O.			Part II. Other significant conditions of	contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.			pute to the cause of death? 3 Probably 4 Vunknown		
Vital Records,	w requires in spaces of the sp	Completed						24a. Was a	an 24b. W	ere autopsy findings available		
Rec	sician; The law in certificate has be lirector, page 2 s	Com						autop perfor 1 Yes	med? de 24 No 1	rior to completion of cause of eath? Yes 2 No		
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	al silis	te: To	27. Manner of Death	1 Inpatie 28a. Date of injur (Month, Day	ent 2 ER/Outpatien y 28b. Time of injury	t 3 □ DOA 28c. Injury	4 ☐ Nursing H at	ome 5 Resid	ence 6 🗌 Other ow injury occurred			
lon	Attending Priystoran; at death. ector After this certific by the funeral director.	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b	n			Yes 2 □ No					
<u>^</u>	urs after ral Dir		4 Homicide determined	building, etc				City or Town	n, State)	or Rural Route Number,		
29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and more of the cause (s) and more of								nd place, and due	to the cause(s) and manner stated.			
		}	30. Name and address of person who	MA MD	eath (Item 23a) (Timo D	Res	001		06/21	(112		
			Jinny Ha	22 Sow	n Greene	- Smeet	Bultim	wre, MI	0 21201			
١,	Stat Registra	<u> </u>	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	bares						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2334 Certificate of Death 2. Date of Death 3. Time of Death Physician/ * Month Kober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BACTIMORE AGNES HOSPITAL 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min 1 M 2 🗆 F **Director** 6 28a-f show with the Maryland 10a. State City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** MD Howar umbia 1 Yes 2 No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 9 23a 21044 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonoe. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Gallege (1-4 or 5+) Elementary/Secondary (0-12) astor tyeurs Be Eather's Name (First, Middle, ပ (Wife) ormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura) 10975 ille larksuilled 20a. Method of Disposition 20b. Place of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State indsor Mill. 4 Donation 5 Other (Specify) 21. Silvanare of Funda Service Licens Amore 23a. Part 1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition dy Medical resulting in death) **Examiner** au Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Kule ran 0 W OY all Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and attending physician Physician/Medical 'au 0 Hospital or Attending Physician: The law requires that the death certificate be Youn Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by neral Director: After this certificate has been signer filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Yes Yes 2 1 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tyes 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MP 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON MAY 32. Registrar's S State Registrar

DHMH 17 Rev 06-2011

Emmanuel W. Bullock	Emmanuel	M.	Bullock	
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2012	2334	2
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nmanuei Ni. B		State of Maryland / 1-For State Registrar	Certificate	or Health and Menta of Death		201 g. No.	2 2334
Physici edical Exami	an/	1. Decedent's Name (First, Middle, Last) EMMANUEL MAYAU	is Bullo	nck.	2. Date of Deat Month July 20, 20	h Day Year	3. Time of Death 0945 hrs
Carlon, Marie Land		4a. Facility Name (if not institution, give street and number)	Don	4b. City, Town, or Location of D	Death	4c. County of Death	
		743 Linnard Street 5. Social Security Number 6. Sex 7. Age	e (In vrs. last birthday)	Baltimore If Under 1 Year If Under 2	4Hrs 8 Date of Bird	h(MM/DD/YYYY) 9. Birth	place (State or
Funeral Director		218.98.9567 1×1 20F	3 Yr	Months Days Hours	Min. 11 03	Foreign	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca				10d. Inside City Limits
Maryland 28a-f shnw d at once.	tor	MD NIA	130	ltimore)			1 Yes 2 No
MD 21215-0036 1 should help within 72 hours after death with the Maryland 1 should Higgine. 27 is marked uther than "natural", ur items 23a nr 28a-f shu umatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 743 Linnard Stree	+	10f. Zip Code 2/229		og. Citizen of What Count US/	i l
eath wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2		/as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu		White, etc.	
safter d ral", m	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade com	1	Yes 2 No specify:	d - £ d	Specify: 45/0	.01-
72 hour n "natu al Exan	eted	Elementary/Secondary (0-12) College (1-4 or 5	during r	most of working life. DO NOT use	e retired)	Atlantic	· ·
5-0036 led within 72 hours Hygiene. nther than "natur	Completed	17. Father's Name (First, Middle, Last)	ton	K Lift Operatz	Name (First, Middle, N	Prod.	ucts
21215-0036 Muld be filed within 7 Mental Hygiene. marked rither than	Be	Emmanutel E. Bullock	٠		maine		-0
Baltimore, MD 21215-003 Depriit. Pages I and 2 should be filed within Ingestment of Sel and 2 should be filed within Important. If item 27 is marked on the ringing or other transmatic event, the Med	၉	19a. Informant's Name/Relationship (Type, Print) Charmaine Smith/Moth		ng Address (Street and Numbe ら OSWLGO AVJ			
Te, M 1 and 2 Health Fitem 2 or traus		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta	20b. Place of Dispo	sition (Name of cerhetery,	Date	20c. Location - City or T	own, State
Baltimore, permit. Pages 1 an Department of Hea Important: If iter njury or other tri		4 Donation 5 Other Specify:	King Men	Drul Park Name and Address of Facility	7727/2012	WindsorN	MI MD
Ball permit Depar Impo		21. Signature of Funeral Service Licensee	22. E	Name and Address of Facility V	aughn C. G	areenefuno Vulatonn Mi	21133
Physician	V 13	23a. Part I. Enter the disease, or complications that caused failure. Ust only one cause on each line.	the death. Do not enter				Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a conse	quence of):				Death
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Hanging Due to (or as a conse	guence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	- 1900 C				
50, te be executed nysician and burial - transit	al Ex	events resulting in death) Last Due to (or as a conse					
60, ate be exe hysician a e burial -	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome.	on of programmy			23d. Date of delivery	
687(ertifica ding ph	ian/N	23b. Was decedent pregnant in the	2 F	etal death 3 Ectopic pr	egnancy	Month Da	ay Year
Box te death of the atten ted for us	Physician/A	1 Yes 2 No 9 Unknown 9 Unknown	time or death 5 C	Other (Specify)			
ires that the signed by the detach	by PI	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I		bacco use contribute to the 2 No 3 Proba	
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of Vital Records, ig Physician: The law requirements certificate has been so neral director, page 2 should	Completed			100	autop: perfor 1 Yes 2		m=-3
Ital Recions: The certificate rector, page	å	25. Was case referred to medical examiner? Hospital: 1 Inpatie		26.Place of Death (Ch		Residence 6 🗸 Other:	6
of V ng Phys After this meral di	5	1 ✓ Yes 2 No 28a Date of Joint	ry 28b. Time of		28d. Describe h	now injury occurred	Scerie
Division of a standing Pheragon of an or Attending Pheragon. The Director: After the increase of the funeral of the funeral or the funeral o	atio	1 Natural 5 Pending FOUND: Day,Yr Jul 20, 2012	0941 hrs	1 Yes 2 ✓ No			15 (1)
Divisi pital or At ours after d teral Direct filled in by	Certification:	Suicide Could not be	ury - At nome, farm, stre whouse	eet, factory, office building, etc.		itreet and Number or Rura tate) treet, Baltimore, MD	al Route Number, City
Hos Pur fely		29a. Certifler 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of example.	knowledge, death occu	urred at the time, date and place,	, and due to the cause	e(s) and manner as stated	d. cause(s)
Tn the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier	Threaten and or myestige	29c. License number	rod at the time, date t	29d. Date signed (Mont	
		Mle Brassell M	B	O.C.M.E.		July 21, 2012	
		30. Name and address of person who completed cause of do Melissa Brassell, MD Assistant Medical	,	V. Baltimore Street, Balt	imore, MD 2122	3	
	tate		's Signature				
Regis	trar	III 2.4 2012 /2	barke				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item per in 8930 8-2-12 Vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Burkhart 17^{Day} 13:48 Physician/ 201^{vea} July Elizabeth Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 7. Age (In vrs. last birthday **Funeral** Days Hours Country 081-28-5050 75 Director 1 🗆 M 2 🗓 F Yrs May 18, 1937 NY. Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Sykesville 1 Yes 2 X No Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21784 2202 Carroll Highlands Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death v 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married þ Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Valeria Evelyn Heier Gordon Leslie Pfohl 19a. Informant's Name/Relationship (Type, Print)

Mr. Charles E. Burkhart (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 and l 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important; If item 27 is any injury or other trau 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State All County Cremation 7/23/2012 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses Guan Haurs PO Box 195 Sykesville, MD 21784 MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ULMONAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list a inditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events nding physician and The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760<Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant a
9 ☐ Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 N death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending iniury 24 hours after death. Funeral Director; A Accident Investigation Suicide 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I only one) 29b. Signature and D005955d 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NACANIA 700A POOLE RP WESTMINSTER MD 21157 32. Registrary Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2150 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins 8. Date of Birth **Funeral** last birthday) 9. Birthplace (State or Foreign Country) MA 026-34-2934 66 04/30/1946 Director 1 □ M 2 🔀 F MA 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MA Hampden Agawam 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2G Castle Hills Rd. 01001 USA items ural", or iten ا Examiner ا Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No þ 1 Never Married 2 Married Black, White, etc. 1 Yes permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Fund Raiser Non-profit Organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armand Phaneuf မ Annette Maffier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 705, West Warren, MA 01092 Christopher Bagg/ Son item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springfield Street 07/28/2012 Agawam, MA 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licenses Bailey Funerally Home and Cremation S 4023 Annapolis Rd., Halethorpe, MD M01452 Mel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician/ Pancreatic Metastatic Medical Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a conse uence of physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as t attending IF FEMALE: ase 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ Year Month Pregnant at time of death Day signed by the a ld be detached f Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has Je 2 autopsy performed? Yes 2 No page certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this uneral Director: After the fy filled in by the fire 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending М Accident Investigation Suicide 6 Could not be To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D.

State

31. Date filed (Month, Day, Year) 24 Registrar

Westbrook Mitchell

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tda Blake May 07 16 2012 6:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare - Hammonds Lane Brooklyn Park Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Director 218-14-5351 1 □ M 2 🔀 F 87 03/28/1925 Maryland Usual Residence of Dece show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 28a-f MD Anne Arundel Glen Burnie 1 Yes 2X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 15 Greenwood Avenue 21061 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural" 3 X Widowed 4 □ Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mr. Keith J. Blake / Son 11539 Franklinville Road Upper Falls, MD 21156 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of 1
Important: If it cemetery, crematory or other place) 1 Durial 2 Durial 2 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 07/20/2012 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW MO1479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Ph_sician/ advan disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760² IF FEMALE es, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregn 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate ha perform death?
1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗋 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural work? 5 Pending 2 🗌 No within 24 hours after death

To the Funeral Director; completely filled in by the Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injúry - At home, farm, street, factory, office building, etc. (Specify) determined 28f, Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one MD 21061 Jennifer Ried

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 Catherine Barber 2012 10:32A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood Mandrin Inpatient Care Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 220-03-5593 Director 1 □ M 2X ☐ F 99 05/28/1913 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🖾 No Severn Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 U.S.A. 8167 Quarterfield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. White 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Delicatessen 12 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bishop Stricker Mary Α. Charles Joseph 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty Jean Stickell 24 Highview Drive Woodbridge, NJ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 107/27/2012 Baltimore, MD 21. Signature of Funeral Service Licensee MQ1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ S12515 disease or condition Medical resulting in death) Due to (or as a cons Examiner Streetococcus Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for self-consoreinne of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Ineral Director: After this certificate if y filled in by the funeral director, pag 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only oпе) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 Yes Hospice မ 1 Compatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
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To the Funeral D

completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 20/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0/16-31. Date filed (Month, Day 32. Registrar's Signature

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State 31. Date filed (Month, Day, Year) 32. registrar's Signature		204		1	completed cause of de	eath (Item 2		. /	Deran	لعا	ST	Tav.	SON	no)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20Î2 20 8:30 P. M Christina Bryce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maria Health Care Center Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min 261-27-2208 **Director** 1 - M 2 X F 89 Aug. 15, 1922 Massachusetts show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 28a-f 1 Yes 2 X No Baltimore Maryland Baltimore 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6401 N. Charles Street 21212 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Educator Education 4 years traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unk. Catherine J. Chisholm 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles Street Baltimore, Maryland 21212 Sr. Bernice Feilinger, S.S.N.D. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 7-25-12 Villa Maria Cemetery Glen Arm, Maryland Signature of Funeral Service Licensee ²², Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland Ferras 2121223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between greet and Seath Immediate Cause (Final ONGESTIVE Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last and attending physician I for use as the buria Physician/Medical certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day Year Pregnant at time of death 5 Other (specify) detached the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed has completely filled in by the funeral director, page 2 this certificate 1 Yes 2 No Yes Division of Vital • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (C eck only one) Be 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 A Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 3 only one 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name cause of death (Item 28a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ ORRINE BROWN 20% 1:50 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Elizabeth Nursing Home Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign . Carolina 230-18-6097 1 □ M 2 🕱 F 88 0472071924 N. **Director** Usual Residence of Decedent 3a or 28a-f show the notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD N/A 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a oner must be Funeral 4221 Euclid Ave. 21229 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc , or þ 1x Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
St. Elizabeth (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than traumatic event, the Me 4th Grade (0-12) College (1-4 or 5+) Sr. Aid Companion Nurse& Rehab Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type: 🗚 and child 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Jacqueline Brown Faulkner 4221 Euclid Ave., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of INK Date 20c. Location - City or Town, State 1 Burla 2 4 Donation √al 2 X Cremation 3 ☐ Removal from State on-site Crematory Baltimore, MD Other (Specify) Sonati e of FM ral Service Licen ²Joseph Forown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the Immediate Cause (Final Physician/ PROMIARY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Sue to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 as 1 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Pregnant at time of death 9 Unknown detached g Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s certificate has been signed director, page 2 should be det CHRONIC KIDNEY DISEASE Stage 4: ISCHEMIC 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed CARDIOMYOPATHY, HYPERTENSIVE CARDIOVASCU LAR 24b. Were autopsy findings available prior to completion of cause of death? DISEASE, MITRAL REGURGITATION, SICK SINKS SYNDAP 1 Yes 2 🗌 No 25. Was case referred to medical Be examiner? မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Hatural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hount to the Funer completed file (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29c. License number 000/8-362 29b. Signature and title of certifie gural Korauf 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Ave, Ste LIO. Baltimore K Dana Wilkens 31. Date filed (Month, Day, Yeat) State 24

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1 Q 2012 Callahan 10:45P M T111v Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore Co. Towson 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Hours (Month, Day, Year) Director 216-36-7158 1 M 2 XF Yrs 77 March 21,1935 Ohio ir than "natural", or Items 23a or 28a-f show the Medical Examiner rough be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Tes 2 No Baltimore County MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21224 Funeral 621 47th Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian. 11. Marital Status Black White etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 1 and 2 should be filed with thealth and Mental Hygien item 27 is marked other to their traumatic event, in 5 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alice Sellers Richard Bainum, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Donna Geppi (Daughter) Windsor Mill, Maryland 21244 8614 Inwood Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 7/23/2012 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease or complications that caused shock, or hand line. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cluse (Final disease or condition Physician/ Medical resulting in death) Due to (or as a donsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Records, P.O. Box 68760

The law requires thet the death certificate be executed attending physician and I for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 Probably 4 🗆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) of Vital æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending X Natural n 24 hours after death. Ie Funeral Director: Aft bletely filled in by the fur Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only o Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa 29c. License number 18217000 se of death (Item 23a) (Type, Print) St. #4105, Baltimore 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day 6:58A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death 405 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Months Hours Min (Month, Day, Year) 8059 Director 1 № M 2 🗆 F 86 7-1926 in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 □ No mi) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 IJSA 12 Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☑ Widowed 4 ☐ Divorced Dlac Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene, Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ျှ Page 1 and 2 should be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State semetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Tarr Signature of Funeral Service Licensee 22. Name and Address of Facility MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE မှ 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury 1 Yes 2 No Investigation 24 hours after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Pay Year) 32. Registrar's Signatu State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont 18^{ay} Physician/ OKSOON nano 1:30 PM 2012 Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Kockville Montgomen Grove Hospita 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Min. (Month, Day, Year) 460-31-0259 1 □ M 2 € F **Director** 62 Yrs. 20, Korea Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director Yes 2 □ No be notified omen Monta 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Way 23a Funeral 208 USA raven Medical Examiner must death "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent L.C. Armed Forces? 1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates Hsian 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mee Baltimore, Maryland 2121 ife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ KIN tae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a.,Informant's Name/Relationship (Type, Print) > Way totomac 000 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Crematio noval from State 5 Other (Specify) 4 Donation ervice Licensee 21. Signature of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ven tricular Onset and Death Immediate Cause (Final tibrillation Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** metastatic CUVS Oveas Sequentially list conditions, Examine Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as attending plant of lor use as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Day Year Month isigned by the arild be detached f 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, is certificate has been sidirector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockrill, namlare 20850 Medical Buzy, MD 9901 center Drive 32. Registra s Signature 31. Date filed (Month, Day, Year) State Registrar

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CHANG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death PASE Physician/ 02:10 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE THEJOHNS HOPKINS HOSPITAL N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday) **Funeral** Months Hours 218-52-2078 **Director** 1**X** M 2 □ F 57 Jan 11, 1955 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2 No Maryland Baltimore County Cockeysville 10e. Street and Number 10g. Citizen of What Country? Funeral USA 10708 Westcastle Place 21030 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Plumbing supplies Salesman other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, nd Mental ! ည Grace Margaret Sherman and 2 should be Allen Case, Sr. ant of Health and Mit: If item 27 is ma y or other trauma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael A. Case (Son) 8 Lovett Court, Timonium, Maryland 21093 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: I any injury o Metro Crematory, Inc. 7/19/2012 Signatur of Ferena Servi (Licens e Martin D. Lawson Catonsville, Maryland MTTCHELL WIEDEFELF FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hectrical Arrest Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine It any, leading to immedicause. Enter Underlying Cause (Disease or injury ed by the attending physician and detached for use as the burial-trar that initiated events resulting in death) Last Physician/Medical irrhosis or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ieral birector. After this certificate has filled in by the funeral director, page 2: autopsy performed 1 Yes 2 No 1 🗌 Yes 2 📝 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA Manne of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 100 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who ORLEANS STREET BALTIMORE MD 21287 ARINA SAHETYA

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month,

1800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Edward Dukehart Coale 2012 9:40 A July 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Darlington 1224 Holloway Road 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1 X M 2 □ F 7, 1934 78 Maryland Director Apr. 215-32-8741 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examinations to notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Darlington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1224 Holloway Road 21034 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Transport 12 Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Marie Dukehart Harry Edward Coale Sr. or other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 Is
any Injury or other trau Ethel M. Coale / Wife 1224 Holloway Road, Darlington, MD 21034 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn. 7-25-12 Aberdeen, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee lessica of weaver 1317 Cokesbury Road, Abingdon, MD 21009 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the m. de of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nonth **Physician** disease or condition resulting in death) /Medical Due to (or so consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 €NO 1 ☐ Yes 2 110 Hospital or Attending Physician: 24 hours after death. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 **D**No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

29b. Signature and title of certification

DHMH 17 Rev 1/2001

and manner stated.

29d. Date signed (Month, Day, Year)

			1 - State of Maryland / De Registrar	epartment of Health and M Certificate of Death			2 23355			
		,	Decedent's Name (First, Middle, Last)	oranidate or Bodan	2. Date of Deatl		3. Time of Death			
	Physicia Medic		LEO WILLIAM COLLERAN		JULY 2		3:17P M			
	Examir	ier	4a. Facility Name (if not institution, give street and number) STELLA MARIS	4b. City, Town, or Location of Death TIMONIUM		4c. County of Deat				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	g. Bir	thplace (State or Foreign			
	Director		213-05-9823 Usual Residence of Decedent		(Month, Day, 2–8–191		ARYLAND			
	e filed within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ţō	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits			
	Mary 28a-f	Funeral Director		ALTIMORE			1 X Yes 2 □ No			
	vith the 23a or st be r	ral	10e. Street and Number	10f. Zip Code 21206	1	0g. Citizen of What Co USA	ountry?			
	eath w	-une	6207 ALTA AVENUE 11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Ame	rican Indian,			
36	after d	ρ	1 Never Married 2 Married 1 No	4 🗆 v . o 🕶	lican, etc.)	Black, White Specify:	e, etc. WHITE			
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	3 Uvidowed 4 Univorced Year or Dates. 1941-1942	cedent's Usual Occupation		16b. Kind of Business/	Up di spin			
215	in 72 h e. nan "n	dmc	(Specify only highest grade completed) (Gi	ve kind of work done during most of workin. DO NOT use retired)	g	TOD. KIND OF BUSINESS/	industry			
7	d within dygiene. ther thar nt, the M	BeC	10TH #	ACCOUNTANT		BALTIMORE	TRANSIT			
/lanc	nould be filed nd Mental Hy s marked oth smatic event	10	17. Father's Name (First, Middle, Last) MARTIN T. COLLERAN	18. Mother's Name MARY ANNA						
Baltimore, Maryland	2 shou th and 27 is rr traum	17	19a. Informant's Name/Relationship (Type, Print) ANITA COLLERAN NIECE	ailing Address (Street and Number or Rural 1307 M SHERIDAN		City or Town, State, Zip				
ore,	permit. Page 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	sposition (Name of Date of Dat	ate 2	20c. Location - City or	Town, State			
tim	it. Pag rtment rtant: njury o		4 Donation 5 Other (Specify) MOST I	HOLY REDEEMER 7-25-		BALTIMORE,				
Bal	Depar Impo any ir		21. Signature of Funeral Service Licenses	22. Name and Address of Facility SCH 9705 BELAIR ROAD		HAM, MD. 2				
	Physician/ Medical Examiner	iiner	23a. Part 1. Enter the disease of complications that caused the death. Do not eshock, or bear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0 1 1		st,	Approximate Interval Between Onset and Death			
8760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d							
. Box 687	requires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	livery Day Year			
rds, P.O.	equires that the sensioned bould be detailed.	by	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?			
Division of Vital Records,	To the Hospital or Attending Physician: The law n within 24 hours after death. To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 st	Completed	25. Was case referred to medical		24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of			
Vita	ysicia s certi directi	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Check of D		nce 6 🗆 Other (Speci	ifu)			
ō	ng Ph		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year)	of 28c. Injury at 28		v injury occurred				
sion	vttendi death. ctor: A y the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	9f Loagtion /Star	not and Number or Pu	and Pourte Number			
Ξ	al or A s after al Dire ed in b	S	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Richty or Town, State)							
_	ie Hospit n 24 hour le Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dear 2 Medical Examiner: On the basis of examination and/or involved to the best of my knowled e, dear to the best of my	restigation, in my opinion, death occurred at the	he time, date and	place, and due to the o	cause(s) and manner stated.			
	To the To the comp	~	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	, Day, Year)			
	aul		* gestere Theis CRNP	R043580		07-83-0	2012			
	12x1		30. Name and address of person who completed cause of death (Item 23a) (Type JUSTINE PREIS, CRNP 2300 DULANEY	,	IUM, MD	21093				
Ì	Stat Registra		31. Date filed (Month, Day, Year) 32. Begistrar's Signature	THE TOTAL THOM	_011, 110					
	-5		JUL 4 4 CUIZ / Trace 8. A	acking	-					

JULY 22, 2012

LEO COLLERAN

12-05117 Unk Unk

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nk Unk		State of Maryland / Departm		lygiene	201	2 2335				
Physicial Physicial Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) Kevin Caldwell	400.204.	2. Date of Death	No.	3. Time of Death 0144 hrs				
d distribution of the state of		Facility Name (if not institution, give street and number) Columbia Park at East Marlboro Avenue	4b. City, Town, or Location of Deat Hyattsville	h	4c. County of Death Prince George	's				
Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last bir 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rthday) If Under 1 Year If Under 24Hr Months Days Hours Min	s. B. Date of Birth	(MM/DD/YYYY) 9. Birt Foreig Cou	hplace (State or n Wash. ^{untry)} DC				
th the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent 10a. State	Washington	10g	. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No				
r death with the N or items 23a or must be notified	Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced If Yes, Give Year	S • E 20032 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	J.S.A. 14. Race - Americ White, etc. Specify: B1	can Indian, Black,				
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref		6b. Kind of Business/Ir					
Baltimore, MD 21215-0036 gernit. Pages 1 and 2 should be filed within 7 bepartment of Health 2 is marked offer than Important: If tiem 2? is marked offer than injury or other traumatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Richard Caldwell	Hilda	e (First, Middle, Ma	on					
and 2 should and 2 is mater and 2 should lee to 27 is mater at a material	To	Dewitt Jacobs (uncle) P	b. Mailing Address (Street and Number or O. Box 703 Shept of Disposition (Name of cemetery,	nerdstov		443				
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State cremat	ite Crematory 7-	24-12	Baltimor	e, MD				
ம் திறிந் Physician , /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	Ave., E	Baltimore	MD 2121 Approximate Interval Between Onset and				
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ision of Vital Attending Physician: ar death. rector: After this certif	cation:	1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation fd 7-8-12 fd	Time of Injury 28c. Injury at Work? 1 2:53 am 1 Yes 2 X No		struck by					
Divis To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in the	Street Mailboio Ave. hyatts									
To the B within 24 To the F complete	The state of the cause (s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Inc.) 29d. Date signed (Month									
(F)		IM, le	O.C.M.E.		July 8, 2012	, vay, rear)				
		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 90 31. Date filed (Month, Day Year) 32. Registrate Signature.	00 W. Baltimore Street, Baltimore	, MD 21223						
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature								

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

estor Devened		1- For State Registrar	e of Maryland /		tificate of De		id Merita		Reg. No. 20	12 2335
Physici		1. Decedent's Name (First, Middle,L						2. Date of Dea		3. Time of Death
ledical Exami	ner	Nestor Lawre		necia				July 19, 2	2012	1935 hrs
		4a. Facility Name (if not institution, of 605 Park Avenue Apt. 2				ity, Town, c altimore	or Location of [Death	4c. County of De	A
Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. la	ast birthday) If		irth (MM/DD/YYYY) 9.	Birthplace (State or		
Director			, ALOU, 112 25 01							reign Hilippines Country)
any		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City,	Town or Location	-				10d. Inside City Limits
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Mary r 28a-	Director	10e. Street and Number			10f	. Zip Code			10g. Citizen of What C	ountry?
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MD 2 d 2 shoul Ith and M n 27 is m	욘	19a. Informant's Name/Relationship Eleanor de Vened		mber, City or Town, St Lumbia, MD						
e, MC 1 and 2 sl Health ar item 27		20a. Method of Disposition	,		Place of Disposition (Name of co		Date	20c. Location - City	
MOFE Pages 1 cent of H int: If i		1 Burial 2 Termation 3 4 Donation 5 Other Speci		Met			Inc.	07/23/12	Baltimor	re, Maryland
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	ľ	21. Signature of Funeral Service Lic	ensee Thomas G	rego	22 Name	and Address	es of Facility			
Physician	11 15	23a. Part I. Enter the disease, of cor	mplications hat caused th	e death.	299] Do not enter the mo	Freder	rick Ro	pád Baltí diac or respiratory an	more, Mary	land 21228 Approximate Interval
- /Medical		failure. List only one cause on	each line.U a. Atherosclerotic C.							Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conseq							
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8760, ificate bug physic	W/L	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregn	ancy 2 Fetal de	ath 3	Ectopic pr	regnancy	23d. Date of deliv	ery Day Year
Box 6876: death certificate the attending phy	Physician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at tir	ne of dea						
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Accol	d mo								rmed? death	?
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= = 1	ö	1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day,Year	r)	200. Titlie of Injury	1 1	Yes 2 No		now injury occurred	
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To To COI	ğ	29b. Signature and title of certifier	and manner stated.			29c. Licen	se number		29d. Date signed (A	Month, Day, Year)
		auess				O.C	.M.E.		July 20, 2012	
	Ì	30. Name and address of person wh Ana Rubio M.D., Ph. D.	o completed cause of dea Assistant Medica	•		Baltimor	e Street R	altimore. MD 21	1223	
St	ate	31. Date filed (Month Cay, Year)	32. Regis rar's			_ =				
Regist	rar	JUL 24 ZUIZ A	even b.	gran						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Genevieve DeCosmo 2012 R. 1:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dundalk Baltimore Co. Genesis Heritage Eldercare Ctr. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min (Month, Day, Year) 216-07-9441 **Director** 1 M 2 X F 93 Jan. 28,1919 Maryland Usual Residence of Decedent 28a-f shov the Maryland 10c. City, Town or Location at 10d. Inside City Limits Director notified 1 Yes 2 X No MD Baltimore Essex 10e. Street and Number r items 23a or iner must be n 10f. Zip Code ò 10g. Citizen of What Country? Funeral 1000 Franklin Avenue 21221 United States Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 27 is marked other than "natural", or ite traumatic event, the Medical Examiner Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify 'natural", If Yes Give 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leonard Sliwinski Marie Tomasliewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7014 Gough Street Mr. Gerald F. DeCosmo(Son) Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 X Other (Specify)Entombment St. Stanislaus Cem. 7/20/2012 Baltimore, Maryland 21. Signati of Funeral Service License 2 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Examiner Section tally list conditions if any, leading to immediate cause. Enter Underlying Examine use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No Yes the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 certificate has autopsy prior to completion death? 1 Yes Yes or Attending Physician: 25. Was case referred to nedical Be 26. Place of Deat heck only one) examiner? Other: ဂ္ဂ 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury atural 5 Pending 1 Yes 2 No Accident Investigation Could not be the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month 11:45 AM Medical Edward Elliott DePrine Sr 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min Hours 1 № M 2 🗆 F **Director** 84 213-30-8770 Apr 03, 1928 Maryland sual Residence of Deceder 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Alston Rd 21093 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ₩ Widowed 4 □ Divorced Specify: Completed Year or Dates. 1950 - 54 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Western Electri Be 17. Father's Name (First, Middle, Last) 1 and 2 should be filed f Health and Mental H item 27 Is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Claude D. DePrine Annie Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Wendy Mancini /Daughter 12 Ferns Ct. Lutherville, MD 21093 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 6 permit. Page Department (Important: If any injury or once, Jul 24 4 Donation 5 Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematori 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1585 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ONGESTI HEART Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading clause in media, cause. Enter Underlying Cause (Disease or injury Due to (or as a nunsequation of) Exami after death.

Director: After this certificate has been signed by the attending physician and in hv the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, COLITIS 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DECUBITUS ULCOR 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 HO ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete ath (Item 23a) (Type, Print) State 2 4 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4c per doc g929 7-31-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ A^{M} 07 2012 12:27 DiAngelo Medical Jesse 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil. New (Warwick 368 Joe Metz Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 04/13/1958 Months Days Hours Min. Country) Delaware 1 ₹ M 2 □ F Director 221-46-8384 54 Yrs Usual Residence of Deceden Pege 1 end 2 should be filed within 72 hours after death with the Marylend ment of Health end Mental Hygiene. tent: If item 27 ie merked other then "nature!", or iteme 23e or 28e-f ehoi ury or other treumatic event, the Medical Exterior miner must be notified at 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location Directo 1X Yes 2 □ No Middletown New Castle DF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19709 USA 8 Biggs Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. leted by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Compl (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation / Waste Truck Driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Dogherty William DiAngelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 56, Townsend, DE 19734 Kathie DiAngelo / Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1 e
Department of IImportent: If ite
eny Injury or ot 1 ☐ Buriał 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/18/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Doubo Dorota Marshalk Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Liver Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ettending physicien end I for use es the burial-trensit or Attending Physicien: The lew requires that the deeth cartificate be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death To the Hospital or Attending Physicien: The lew requires that the dee within 24 hours after death.
To the Funnerel Director: After this certificate has been signed by the e completely filled in by the funerel director, page 2 should be deteched. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 M No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? dangiter's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier MSRajapa 00057465 5 703 Baltimore MD 21709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSRGAPAKSEMD 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day3 Karen 2012 10:45 AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6710 Parkwood Street Hyattsville Prince George's . Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 39 9. Birthplace (State or Foreign Country) Unkn. . Age (In yrs. last birthday) **Funeral** If Under 1 Year Days 1 ... M 2 XF 520-42-5918 72 **Director** Yrs. Usual Residence of Decedent or 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD Hyattsville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6710 Parkwood Street 20784 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Noivorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Consultant permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unkn. Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope M. Parker / Friend 12913 Alton Square, #215, Herndon, VA 20170 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛚 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 7/25/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall oucle Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death neoplasm Physician/ disease or condition resulting in death) rears Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine cause. Enter Underlying Due to (or as a consequence of) death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death i signed by the aid be detached for To the Hospital or Attending Physician: The law requires that the onthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes CO315100 2 No ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director; After completed filled in by the funer 1 Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ertific 29d. Date signed (Month, Day, Year) 07-23 -2012 025001 erson who completed cause of death (Item 23a) (Type, Print)
LIPPMAN MO 9200RASIL LARGO MO 20774 CT

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 421PM WILLIAM ALLAN DEAR, JR., 2012 0. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore City Union Memorial Hospital If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Months 218-28-1666 **Director** 1 X M 2 - F 80 Mar 9, 1932 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland notified at Director Baltimore City 1 X Yes 2 □ No N/A Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 er than "natural", or items 23a or the Medical Examiner must be USA Funeral 21218 5 E. 39th Street hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 X Yes 2 D þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: .65–67 White Completed 3 Divorced 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Medical Services Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Stell ၉ Edna William Allan Dear, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 E. 39th Street, Baltimore, Maryland 21218 19a. Informant's Name/Relationship (Type, Print) (Wife) Cathie Knighton Dear Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 7/23/2012 Catonsville, Maryland 4 Donation 5 Other (Specify) 21. Sign / re of Fund Sind 1 / 20 MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cordianyapatry Physician Due to (or as a consequence of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy
Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Yes 2 Unknown isigned by the all of the all of the second Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 Yes 2 No Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work?
1 Yes 2 No injury 5 Pending 24 hours after death. Funeral Director: Al Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature 4M:W) 7/20/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jam, 201 E. University PKWY, Baltimore, MD 21212 7

Registrar DHMH 17 Rev 06-2011

State

Adulya 31. Date filed (Month Bay, Year)

State Registrar Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2012 July 17. 3:30 P M Carol Lynn Eddy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Marlboro 14559 Candy Hill Road Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 212 54 6962 62 1 M 2 X F Washington DC Aug 5, 1949 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 V No Maryland Prince George's Upper Marlboro 10e. Street and Numbe 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral 14559 Candy Hill Road 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. 2 X No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self Employed Commercial New Homes Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be fill thent of Health and Mental rtant; If item 27 is marked or jury or other traumatic even ပ Madeline Banev Joseph King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Eddy, Sr. (Husband) 14559 Candy Hill Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Department c Important: If any injury or July 25, 2012 Clinton MD Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service License Ferry Road, CLinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to in reclaim cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 X No
9 Unknown for Month Day Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? Yes 2 X No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **X** Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29c. License number 0 D003048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registr<u>ar</u> 6188

Oxon Hill

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20, 2012 3:40 P M Reba Virginia Eckert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> Montgomery Bethesda If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) **Director** 578-03-2091 1 M 2 XF Yrs 94 July 27, 1917 West Virginia notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Gaithersburg MD Montgomery ō 10e. Street and Number 10f. Zip Code be 10g. Citizen of What Country? ms 23a must be Funeral 221 Booth Street #315B 20878 United States Page 1 and 2 should be filed within 72 hours after death n "natural", or iterr ledical Examiner r 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 X Widowed 4 Divorced Caucasian Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Owner Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or မ Edward Simmons Martha Alice Waggy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Cheryl Pidone / Daughter 235 Cocoanut Ave. #103 Sarasota, FL 34236 t of Healt : If item ? y or othe Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any injury or ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/24/2012 Woodbine, Maryland Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph_sician Onset and Death disease or condition Urinary Tract Infection Medical resulting in death) Due to (or as a consequence of): Examiner Secsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 3:40pm July 201 Examine Due to (or as a consequence of): the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy detached for in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year Yes 2 X No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? Eckert, Reba 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I thin 24 hours after death. the Funeral Director: After 1 X Natural 5 Pending injury Investigation 1 🗌 Yes 2 🗌 No filled in by the Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the within 2 only one 29c. License number 020 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anitha Chetty 8600 Old Georgetown Rd. Bethesda,

DHMH 17 Rev 06-2011

State Registrar

2012

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MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23366 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician/ Fleckenstein 2012 Clyde Bessie 22 3:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Genesis Heritage Eldercare Ctr. Baltimore Co. Dunda1k Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 214-23-7091 Director 1 □ M 2 💢 F Feb. 21,1925 Virginia 87 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director 1 Yes 2 X No Baltimore MD Dunda1k 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 6829 Belclare Road or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 7 Years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eleanor Clyde Eley John Franklin Stephens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other traur. 6829 Belclare Road Mrs. Bessie C. Wells (Daughter) Dundalk, Maryland 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Sacred Ht. of Jesus Cem.7/25/2012 Dundalk, Maryland ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Conation 5 ☐ Other (Specify) of Funeral Service License ennis Signatu Bulda-Ruck Funeral Home of Dundalk, Inc. b 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EBROVASCULAR ACIDENT Immediate Cause (Final ⊩h, sician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and resulting in death) Last been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 performe death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Mannes f Death 28c. Injury at Certificate: work? 1 \sum Yes 2 \sum No iniury 5 Pending Matural within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Investigation Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of the Cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July2012 6:03 am M Donna Marie Farnum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Owings Mills Baltimore 4503 Eli Drive Unit I 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 029-36-2946 63 Director 1 🗆 M 2 🗓 F 05/21/1949 Massachusetts Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Owings Mills Baltimore Md 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4503 Eli Drive Unit I 21117 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White etc. 1 Never Married 2 Married ģ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced White Completed Year or Dates 11
16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Secretary d 2 should be filed withi alth and Mental Hygien 27 is marked other th Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Ann Marie Collins Donald F. Angelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9150 Gracious End Dr., Unit 203, Columbia, MD 21046 Mrs. Andrea L. Kiel (Daughter) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State All County Cremation 7/24/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature Funeral Service, License Svkesville Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancar disease or condition resulting in death) 12006 to duti7/201 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause Disease or injury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 5 Other (specify) Yes the Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed 2 No certificate Yes 2 N 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined after 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) To the

29b. Signature and title of certifier

MD oncdogs

Registrar

of death (Item 23a) (Type, Print)

Hematology

POD64597

DA 1838 Greene Tree Rd Ste 200 Pikesville, Md 21208

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death reeman Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 South Meadow Drive Anne Arundel Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 1 □ M *\ F 216-42-5261 1944 68 arvland 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Maryland Anne Arundel 1 Yes 2XXNo Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 21060 6 South Meadow Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' any Injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) Line Worker-Assembly Warehouse 10thN/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Simmont Sadie Helen Markell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Chalmers Ave., Glen Burnie, Maryland 21061 William Freeman, Jr. /Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem, Prk. July 19,2012 Elkridge,Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signature of 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Pm. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ase or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death.

Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Robert George, Sr. Month July 21 a 2012 8:07 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** June 24, 1927 220-20-6349 Baltimore, MD. Director 1 □XM 2 □ F 85 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Baltimore County Towson 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 United States 8109 Bellona Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? U.S. Marines Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Korrean Year or Dates Cont Lice 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 04 Mechanical Engineer Westinghouse Corp. 12 other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot rother traumatic ever Ethel Marie Riebert Gardner George should be 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau once. Towson, Maryland Mrs.Jewell(nee Atchley)George 8109 Bellona Ave. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) - Evans, Funeral Chapel and Cremation Services, Inc. 20a. Method of Disposition 20c. Location - City or Town, State (Harford County) Forest, Hill, MD. 1 Burial 2 Cremation 3 Removal from State Sunday, July 22,2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, Jeffrey L. Gair, Sr. OFS 12. Name and Address of Facility Control and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 23a. PM 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ NGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Dav Year been signed by the a should be detached t 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LEFT FEMUR Records, WITH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2: autopsy DIA BETES MELLITUS 1 ☐ Yes 2 No 25. Was ca referred to medical examiner?

1 1 Yes 2 | No Division of Vital æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Accident 5 Pending 2030 P M 1 ☐ Yes 2 🔏 No 07/19/2012 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) \$ | 09 | Sellong AVD 70w50M, Mc 21204 28e. Place of Injury - At home, farm, street, factory, office determined Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

MH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gordon Lee Goff Yuly 22, 2012 13:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Hours 537 46 2779 Director 1 X M 2 🗆 F 64 Washington Aug 24, 1947 Usual Residence of Decedent 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Prince George's Clinton 1 Tes 2 XXNo ò 10e. Street and Number 10g. Citizen of What Country? than "natural", or items 23a Funeral 11601 Thrift Road 20735 United States and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No Specify: 3 Divorced Completed Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work dane during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Military Naval Intelligence</u> Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ည Gordon Downer Goff Martha Elizabeth Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tranonce. Nancy K. Goff (Wife) 11601 Thrift Road, Clinton, MD 20735 20a. Method of Disposition
1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemeterly July 30, 2012 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licenses Ferry Road Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attandance has the continuation of the continuati that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No Other: 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 18 06973 3 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.0 TUAZ 7501 Surratts Road, Clinton, MD 20735 31. Date filed (Month, Day, Year, State Registrar

			For	State of Maryland				Mental Hyg	jiene	0 00071
_			State Registrar		Cer	tificate of	Death	1	eg. No. ZU	2 23311
	Physici	_	1. Decedent's Name (First, Middle, Las Cmma Moe	Glenn				2. Date of Dea Month	Day Yea	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give 1521 Race, Sweet	e street and number)			r Location of Death		4c. County of De	
¥ ¥	Funeral Director		5. Social Security Number 6. S		ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year) _ (irthplace (State or Foreign Country) The CARC Ina
To do	2 3		Usual Residence of Decedent 10a. State, 10b. County	10c. City	, Town or Loc	ation	1	DC TO CK	300	10d. Inside City Limits
od reM	or 28a-f show	Director	Mayland Pla 10e. Street and Number	BAH	MORE	10f. Zip Code		1	0g. Citizen of What (1 🛣 es 2 🗆 No
ath Wijth	s 23a or		1521 RACE Steet		2 40 11	21230	0		LISA	
d 21215-0036 filed within 72 hours after death with the Manufand	Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes or No- o Rican, etc.)	Black, Wh	nerican Indian, nite, etc. AMERICAN
21215-0036	n "natura Medical E	Completed	15. Decedent's Ec (Specify only highest gra	ducation de completed) College (1-4or 5+)	(Give I	ent's Usual Occup kind of work done O NOT use retired	during most of wor	rking	16b. Kind of Busines	
212	Hygiene.	Com	Elementary/Secondary (0-12)	College (1-401 54)	Hor	ne make	R		BUN A	tome.
Maryland	and Mental Hygi is marked other aumatic event, t	To Be (17. Father's Name (First, Middle, Last)	umnins			18. Mother's Nan	ne (First, Middle, i	Maiden Surname) のSoル	
Mary nd 2 sho	alth and 27 is marriage.		19a. Informant's Name/Relationship (Type. Print) GE00	19b. Mailing	g Address (Street RACE	and Number or Ru	o i .	r, City or Town, State	
Baltimore,	0		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐	Removal from State	emetery, crem	sition (Name of natory or other place	ce)	Date	20c. Location - City	or Town, State
III III	Department Important: i any injury o once.		4 Donation 5 Other (Specification 4 □ Donation 5 □ Other (Specification 5 □	(Y) YY	Etro	Cremator		28, 2012	BAHIMON	
Bal	Depa Impo any is		21 Signature of Funeral Service Licer		N.	warme and Addre	ss of Facility	e Funer	Hanore M	1 .6./~.
			23a. P. III. Enter the Insease, or com shock, or heart filure. List only Immediate Cause (Final	plications that caused the death one cause on each line.		er the mode of dyin	ng, such as cardiac	or respiratory arr		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as a consequ	- 0	_ (((110	1,70		
E	xaminer	10	Sequentially list conditions,	b. Due to (or as a consequ	ence of):	1 thy	PERTE	MUION		years
W Settle	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	1					4
8760, gate be exe	sician and burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
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Box	by the attending partached for use as 1	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)	/		23d. Date of d Month	elivery Day Year
5, P.O.	signed by be detac	by Ph	Part II. Other significant conditions o	ontributing to death but not resu	lting in the un	derlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ords	been sig should b	ted b						1 🗆 Y	es 21 No 3	Probably 4 Unknown
Division or Vital Records,	his certificate has be I director, page 2 sh	Completed						24a. Was a autops perfor 1 Yes	sy prior to med? death	
Vita	sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		O#1		ath (Check only on	ne)	
O. Phys	r this ral dir	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of		4 LI Nursing H		ence 6 Other (Spow injury occurred	pecify)
sion:	death. ctor; After y the funer	ation	1 Natural 5 Pending investigation		Injury	28c. Injur Wor M 1	k̂? Yes 2 ☐ No		,,	
<u> </u>	s after de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
Te Hospital	within 24 hours after dea To the Funeral Directo completely filled in by th	Medical (29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the tirestigation, in my o	me, date and place opinion, death occu	e, and due to the durred at the time, d	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the	within To th comp	M	29b. Signature and title of certifier	fry car	100000	29c. Licens	e number	90 2	9d. Date signed (Mo	nth, Day, Year)
	3		30. Name and address of person who	completed cause of death (Item		Print) Wers	Suite 201	Skalzupi	rie MARG	land 21061
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat				- Contra	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death (First, Midte, Last) 2. Date of Death Physician/ 7:00 PM 91. WSOY 2012 Medical not institution, give street and num 4b. City, Town, or Location of Death **Examiner** Montgomen MYMME If Under ast birthday) 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Date of Birth 1 M M 2 58 Months Davs Hours Min. **Director** Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. Cit<u>y</u>, Town or Location 10d. Inside City Limits **Funeral Director** ms 23a or 28a-f s must be notified Baltimore 1 Yes 2 Ko 10f. Zip Code 10g. Citizen of What Country? USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married Black, White, etc. 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r fe. DONOT use retired) Elementary/Seconday (0-12) Be 18. er's Name (First, Middle, ည 91 State, Zip Code) 21207 Important: If item 27 is any injury or other Rural Route Namber, City or Town 6602 20a. Method of Disposition 20b. Place of Disposition, Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ure of Fundral Service License ation 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a con sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last esterolemia ng physician as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month detached 9 Unknown s been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform Yes 2 No 1 Yes **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director; After 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of 04315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Miller M.D. 1838 Greene TM Cd#131 31. Date filed (Month) State 4 2012 Registrar

MDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ John Gilroy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner sallsbi ce If Under 1 Year If Under 2 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1X M 2 | F Months Hours (Manth 27 1935) Cown Maryland 217-56-4770 60 Yrs Director Usual Residence of Decedent or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No Princess Anne MD Somerset 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a o Examiner must be Funeral 30532 Creekview Drive 21853 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ NoArmy If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married iled within 72 hours after Baltimore, Mafyland 21215-0036 1 Yes 2 No Specify. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa onee. Specify 3X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ permit. Page 1 and 2 should be 1 Norman E. Gilroy Marilyn L. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7880 Hurly's Neck Road, Mardela Springs, MD 21837 Robin Kennely / Brother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 7/23/2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unuenying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital PICR Other: 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred **√**2 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatuke and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 205 7410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 37 2/802 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 4 2012 Registrar

12-05348	
Honny Groom	le.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Green, J	r.	State of Maryland / Department of 1- For State Registrar Certificate of Certifica									
Physic cal Exam		Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year July 16, 2012 3. Time of Death 1932 hrs								
		4a. Facility Name (if not institution, give street and number) 601 Wyanoke Avenue Apt. 308	4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A								
Funeral Director		5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 212-48-3684 1 N 2 F 66 Y	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD								
vith the Maryland s 23a or 28a-f show any e notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc MD N/A E 10e. Street and Number E	altimore 10d. Inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country?								
after death v al", or item iner must b	y Fune	1 Never Married 2 Married Armed Forces? If 1 Yes 2 No If Yes, Give Year or Dates: 1	21218 as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify:								
iled within 72 hours Hygiene. Jother than "natur the Medical Exam	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade	nost of working life. DO NOT use retired) Disable N/A								
should be filed value of the state of the st	o Be Co	17. Father's Name (First, Middle, Last) Henry Green Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	18. Mother's Name (First, Middle, Maiden Surname) Hurlease McConnell ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
ages 1 and 2 shount of Health and It. If item 27 is not other traumatic		19a. Informant's Name/Relationship (Type, Print) Edgar Green (Brother) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State On-site Crematory On-site Crematory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number or Rural Route Number or Rural R									
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hysician Medical Examiner		23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
sician and	dical Ex	events resulting in death) Last Due to (or as a consequence or): d. UNPENDED AMENDED AME									
the Hoopital or Attending Physician: The law requires that the death certificate be hin 24 broats after death. the Runcral Director: After this certificate has been signed by the attending physician phetely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Med	past 12 months?	etal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year Other (Specify)								
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ysician: The law requir his certificate has been s director, page 2 should l	1 =	25. Was case referred to medical	autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 26, Place of Death (Check only one)								
ding Physician After this cert funeral directo	-	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	ot 3 DOA Other, Nursing Home 5 Residence 6 Other: Scene								
tal or Attending Physician: The law require rs after death. al Director: After this certificate has been side in by the funeral director, page 2 should be	Certification:	22. Marrier of Death 1									
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical Cert	4 Homicide determined (Specify) found in a	partment 308 Baltimore, Md urred at the time, date and place, and due to the cause(s) and manner as stated ation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To th withir To th	Medi	Patral Pollur	29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) July 17, 2012								
-	State	To Be distant Circut	900 W. Baltimore Street, Baltimore, MD 21223								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ ami. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Residence of Greenbelt Greenbelt 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 432-12-1850 90 Yrs Director Arkansas 07-01-1922 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location with the Maryland Director be notified Greenbelt MD Prince George's Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Number 23a Funeral 20706 9885 Greenbelt Road USA items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status ed Forces? Black, White, etc P þ 1 X Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Black "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Transit Driver Government 2+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Henry Hamilton ျ Bertha Betts permit. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1265 Hamlin Street NE, Washington DC 20017 Jocelyn Williamson (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Hanover, MD 22. Name and Address of Facility Phillip A. Weatherford FS, 21. Signature of Funeral Service Lice res Dr. Havi P-Close 2431 E. Oliver Street, Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 🙎 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and itle 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIGITAL DRIVE LINTHICULA State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Day 2012 Year JULY 19 10:21A M HERBERT HINSON JOE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Director 310-32-3723 1 X M 2 □ F 77 Yrs. May 16, 1935 Tennessee Usual Residence of Decede item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 XNo Frederick Maryland Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21701 **USA** 8008 Broken Reed Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 \(\text{No}\) No 1956

If Yes, Give 1976 Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 1976 Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Navy Submariner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Mental မှ Page 1 and 2 should be ment of Health and Menta Della Adkins Lee Hinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Dawn Hinson, Wife 8008 Broken Reed Court Frederick, MD 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 07/20/12 Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 romai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Examiner months if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 🄀 Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 **X** No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Within 2 only one) 29b. Signature and title of 29c. License number 00030020 2012 attending ind address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a Box 310, walkerville, md. 21793 Ao John A. Shulta, M.M. 32. Registra 's Signature State Registrar

8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Country) Wash, DC 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Federal Government 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Suitland, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Cardiovascular Disease complicated by Approximate Interval Between Onset and Death \mathbf{x} AMENDED #21, per fh, 23a, pt. II, 27, 28a-f, per me, g929 7-27-12 23d. Date of delivery Day Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes 2 No Other Nursing Home 5 Residence 6 🗸 Other: Scene 28d. Describe how injury occurred left ankle subject fractured left ankle hours after death.

uneral Director:
ly filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2900 Sinclair Dr. Temple Hills, MD. 3 Suicide 6 Could not be within 24 hours at To the Funeral I determined (Specify) Residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 2, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 M°2 4 2012 32. Registrar's 9 gnature State Registrar

0815 hrs

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20 Robert Haines, Sr. 2012 Sako 9:05P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5821 Mineral Hill Road Sykesville Carroll Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) March 11,1964 Days Min. Director 216-86-0105 48 Yrs Usual Residence of Decede or then "naturel", or itema 23a or 28e-f above the Medical Examiner must be notified at 10a. State the Merylend 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 Yes 2 No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5821 Mineral Hill Road 21784 USA within 72 hours efter death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end Mentel Hyglene. is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) Demolition/Handyman Construction æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ౖ౭ pe Donald Wesley Haines Barbara Jean Shipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth (Robin Miller (Wife) 5821 Mineral Hill Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of I Importent: If Its eny Injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 7/24/2012 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee MO0764 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or a a consequence of) the ettending physicien end thed for use es the buriel-trensit or Attending Physicien: The lew requires thet the death certificete be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death signed by the e ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, icate hes been sig 7, pege 2 should t Completed 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospitel or Attending Physicien: The within 24 hours effer deeth.

To the Funerel Director: After this certificate it completely filled in by the funerel director, peg 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ည 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K10102 2012

State Registrar

0

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

TOMPR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SCOTT EDWARD HALUSKA JUL 2012 1:20 Medical 4a. Facility Name (if not institution, give street and number) WALTER 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY REED NATIONAL MILITARY MEDICAL CENTER BETHESDA 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Min Hours **Director** 196 48 October Pennsylvania 54 -733Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No PA Cambria Patton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 509 Beech Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Curently Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Specify: White er than "natural", the Medical Exa 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor of Medical Dentistry Health Care event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည George Haluska Saundra L. Stoltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Wife 509 Beech Avenue, Patton, PA 16668 Heather Haluska Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, St. Mary's/St. Georges July 17, 2012 Patton, PA 16668 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moriconi Funeral Home, Inc. 1303 Bigler Avenue, Northern Cambria, PA 15714-0487 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death MALIGNANT MELANOMA ·Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** METASTASIS TO LUNGS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami PNEUMONIA Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Dav Year Pregnant at time of death the P.O. signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2: performed? hin 24 hours after death.

the Funeral Director: After this certificate I
mpleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မ 1X Inpatient 2 \square ER/Outpatient 3 \square DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury 5 Pending X Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c. License numbe 29d. Date signed (Month, Day, Year)

State

BRIAN M. CUNEO, MD

Date filed (Month Day Year)

1 4 2012

1 2 4 2012

1 32. Registrar's gnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

WALTER REED

BETHESDA, MD 20889

NATIONAL MILITARY MEDICAL

CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22, 2012 7:25 A July Torben Bernhard Hansen /Medical a. Facility Name (If not institution, give streat and number) Collington Episcopal Lifecare Community 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Mitchellville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F 24. 1921 Denmark 91 318-12-5400 Director Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show must be notified at 1 ☐ Yes 2 X No Director Mitchellville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a 20721 United States 10450 Lottsford Road #4214 Funeral items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? other traumatic event, the Wedical Exercitive 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2X Married Maryland 21215-0036 ō 1 ☐ Yes 2 XNo Specify. Specify: þ 3 Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Construction Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental H Frida Elisabeth Kloch ပ Johannes Bernhard Hansen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 item 27 is Huntington, MD 20639 996 Warner Dr. Lisa Hansen Rich / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition of 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or Final Journey Crematory 7/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the most shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death t dying, such as cardiac or respiratory arrest, Immediate Cause (Final d411 **Physician** Cele disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner Hospital or Attending Physlcian: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 4 hours after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Directory filled in by 4 Homicide 1 < certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifier

within 2

12200

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avakoli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20° 2012° 10:40P M Jüly Minnie S.M. Hinkhaus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Lutheran Health Care Westminster If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Country) MD Days Hours Min. 0472771917 95 Director 224-46-6620 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State Director 1 Nes 2 No Carroll Westminster MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral death with 21158 USA Mark Way, Apt. 201 st. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 N Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I Health and Merical fitem 27 is marked of a where traumatic even ည Nannie Thompson John Anderson Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 Katesford Rd., Cockeysville, MD 21030 Curtis Mabry-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/12 Finksburg 4 Donation 5 Other (Specify) Evergreen Mem. 22. Name and Address of Facility 21. Signature 11 Service Licensee Fletcher Funeral Home, P.A. St., Westminster, Md., 21157 Þ E. Main Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 23a Part 1 Interval Between Onset and Death immediate Cause (Final Phy i ian/ VARUA cheo M disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA After this 27. Manyler of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural injury work? 5 Pending after death.

Director: Aff 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in 24 hours a Funeral L Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

10

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

Wester STELL MALLES STONER AUBUR I HOMAS K. GALVU 2915 M

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D31660

23/2014

State Registrar

ice w

0805 hrs

Approximate Interval

Death

subject ingested medications

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2032 Harman Ave. Baltimore, MD.

July 17, 2012

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: 24 hours after death. Division of Vital After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

1 Natural

2 X Accident

Suicide

Homicide

29b Signature and title of certifier

State

Medical one)

> Donna M. Vincenti, MD 31. Date filed (Month, Day, Yea 32. Registrar's Signatu

> 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

fd 7-16-12

fd 7:30am

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Residence

1 Yes 2 X No

29c. License number

O.C.M.E.

Registra

Pending

Investigation

Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician/ Ju^{Month} 19, Frank Hough 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Hart Heritage Estates Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. (Month, Day, 175-16-9627 Director 1 🔀 M 2 🗆 F Nov. 27, 1922 89 Pennsylvania Usual Residence of Deceden 28a-f shov 10c. City, Town or Location at 10a State Director must be notified 1 🗌 Yes 2 🔀 No Maryland Harford Street 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a 3708 Grier Nursery Road 21054 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 er than "natural", o 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Owner/Operator Oil Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H Isabel (unk) Henry William (unk) Hough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Department of Health an Important: If item 27 is 1 any injury or other traumone. 1322 Wiley Oak Drive, Jarrettsville, Maryland Amy Lane / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hrospect Cemetery 7-24-2012 Portage, Pennsylvania 21. Si/na ur of Funeral rvice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician Donne disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) -transit that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day been signed by the atte should be detached for 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 No g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 After this certificate has or Attending Physician: The after death. 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 2 Accident 3 Suicide 5 Pending 1 Tes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Dunn, 615 W. MacPhail Road, Bel Air, Maryland 21014

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

03221

29d. Date signed (Month. Dav. Year)

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 20 Day 2012 Arline Kave Howdon 6:26 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 111 Hamlet Hill Road #105 Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-44-1331 Director 1 M 2 K F Yrs. July 21, 1920 New York ms 23a or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland 1 X Yes 2 No N/A **Baltimore** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 111 Hamlet Hill Road #105 21210 U.S.A. : If Item 27 is merked other then "neturel", or items or other treumetic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years Medical Research Cytologist Hygier I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nould be file nd Mentel I merked o မ Harry Kaufman Rosalie Bloomberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) end 2 s Health em 27 i William Dixon Shay, III (grandson) 160 Rolling Road Bala Cynwyd, Department of Healt Importent: If Item 2 eny Injury or other Pennsylvania 19004 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 7-23-12 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland Signature of Funeral Service Licensee Name and Address of Facility Litchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) UNGMedical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): use es the burial-trans Due to (or as a consequence of): ettending physicien for use es the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy
5 Other (specify) ____ Month Day ate has been signed by the e page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Wunknown Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death. Funerel Director: After this certificate has perform 2 No ☐ Yes 2☐ No 1 Yes filled in by the funeral director, Be (**Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ٥ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospitei Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29b. Signature and title of certifier 12 cause of death (Item 23a) (Type, Print) 30. Name and address of person who LCHAGE 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23385 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 06:45 PM Stella K. Indyke July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford Brightview Assisted Living If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min April 30 Parisylvania 95 Yrs 1917 Director 167-01-2956 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland aţ 10c. City. Town or Location Director notified Harford Bel Air 1 Yes 2 X No Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò er than "natural", or items 23a or the Medical Examiner must be Funeral U.S.A. 21014 300 West Ring Factory Road Apt. 105A 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) . Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life, DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Hammaker Own Home 12 Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Kielar permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic to Matthew Kuznar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Recent Dr. Bel Air, Maryland 21014 Dr. Gregory Indyke (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date -----1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 8-24-12 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington, Virginia 22 Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air 21. Signature of Funeral Service Licensee Jeffrey R. Testerman (M01543)lew LUNGEN 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end , Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence 6) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last burial-trans and Due to (or as a consequence of): physician s the burial Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ atten for u in the past 12 months? Day Month Year Pregnant at time of death led by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by det ۵ ک Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 s has autopsy performed? certificate Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗆 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA Living this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: s after death. Il Director: After tl ed in by the funera 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 Natural Accident work?
1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours after the Funeral Dire mpleted filled in b Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2

To the F

complete only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D3 2275 20. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month) 32. State 4 2012 Registrar

			State of	Maryland		tment of F ificate of		Mental Hy	giene Reg. No. 20	12	23386
	Physici /Medi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month Valley	ath Day Z 3 20	Year	3. Time of Death 9:50Au
1	Examir		4a Facility Name (If not institution, give street and numb	oer)			4b. City, Town, or	Location of Death	4c. County	of Death	
			Longview Nursing Home				Manchest			Carro	
	Funeral Director		5. Social Security Number 215−18−1849 6. Sex 1 M 2 □ F 7.	8. Date of Birl (Month, Da Dec. 2	y, Year)	9. Birthp Coun	lace (State or Foreign try) Missouri				
	ryland thow		Usual Residence of Decedent 10a. State 10b. County		11	0d. Inside City Limits					
	e Ma	cto	Maryland Carroll				1 ☐ Yes 2 ☐ No				
VIZIS-5-0020 within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show	h with th	al Dire	10e. Street and Number 2713 Appleseed Road			10f. Zip Code	21048		10g. Citizen of V Uni	What Coun Lted	states
	urs after daat al', or items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Was Decede Armed Force	es? □No 194	13-	as Decedent of H res, specify Cuba	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White,	
7200-617	nin 72 hours n "natural", Vedical Ext	Be Completed	(Specify only highest grade completed)	oation during most of wo d)	working 16b. Kind of Business/Industry						
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9	be filed tel Hÿgi d other event,	Se C	17. Father's Name (First, Middle, Last)	ame (First, Middle,	Maiden Sumam	ne)	_				
yland	should be nd Mentel merked o	70	Salvatore Illari				Nancy	Rosellin	ni		
a	2 sho and I is me		19a. Informant's Name/Ralationship (Type, Print)		_			Rural Route Numbe			
e Ge	and aatth		Jean Illari / Wife	mar etermina			d Road,	Finksbur			
saitimore	Pages 1 ient of Ha nt: If iten		20a. Method of Disposition Date Date Commenter								
Dail	permit. Pa Depertmen Important any injury pnce.		21. Signature of Funeral Service Licensee Alyson	K Tayl	1000000			emation , Baltim			Maryland In
			23a. Part1. Enter the disease, or complications that on shock, or heart failure. List only one cause on each	sed the death.	1			•		L y .L.C.	Approximate
)	Physician /Medical Examiner	e.		orkins		DISTA				1	Interval Between Onset and Death
Ď.	ficate be executed physician end s the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause. (Disaase or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
00/20 X	death certificate be executed e attending physician end od for use es the buriel-transi	/Medical									
20	atten for u	ciar						00h Di 11			the sauce of death?
٦ ک	hat the d ed by the detached	Physician/M	Part II. Other significant conditions contributing to deat			errying cause giv	ren in Part I.		Yes 2□ No	3 Prot	o the cause of death?
cords,	law requires that the death certifias been signed by the attending as been signed by the attending a 2 should be delached for use e	Completed by	CORONALY ARTSLY	SUSSIE	<u>د</u>			24a. Was perfo	an autopsy med?	ava	ere autopsy findings ailable prior to mpletion of cause death?
ב ב	ne lav a has age 2	틹						10	es 2 No		Yes 2□No
ē	in: Tificati		25. Was case referred to medical				26 Place of D	eath (Check only o	•		2.03 22.110
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5	ding th: Afte	ij	1 Accident 5 ☐ Pending (Month, investigation	Day Year)	Injury		rk? Yes 2∐No				
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificata has i completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be datermined 28e. Place of building.	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospita 24 hours Funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis and manner and manner	is of examination							
	Vithir To th	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
			De Nome and address of access via	AND OF CHARLES	23a) /Tuma Pa	Ro S	5852		July 2	32	012
			30. Name and address of person who completed cause of P.O. Box 26/3 Sp/is	Sbury	, MAN	es/nu	2/8	02			
	Sta										
DHI	Registr MH 16 Rev 6/9		JUL 2 4 2012 Server	1. par	Kel	<u>. </u>					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ TOI	Department of Health and N	∕lental Hygie	ne			
		State Registrar	Certificate of Death	1	Reg. No. 2012 23387			
Physici	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death July	19 2012 3. Time of Death 9:55 A M			
Med Exami		Richard S. Ingle 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July	19 2012 9:55 A M			
EXAIIII	Her	231 Ironshire South	Laure1		Prince George's			
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Birthplace (State or Foreign			
Director		475-05-2736 Usual Residence of Decedent 1 ☒ M 2 ☐ F 93	Yrs.	June 18,	· · · · · · · · · · · · · · · · · · ·			
and show l at	5		wn or Location		10d. Inside City Limits			
Maryli 28a-f otifiec	rect	MD Prince George's I	Laure1		1 ☐ Yes 2 💢 No			
h the	a D	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?			
orth with mit mas 2% must	Funeral Director	231 Ironshire South 11 Marital Status	20724	osify Voc. or No.	USA			
6 er des or ite		11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.			
)03) uraft LExal	Completed by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates. 43 1 - 44 1	1 ☐ Yes 2 🔀 No Specify:		Specify: White			
15-(72 hou "nat edica	ple	15. Decedent's Education 16. (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16	b. Kind of Business/Industry			
rithin in the M	S	Elementary/Secondary (0-12) College (1-4 or 5+)	Insurance Comptrolle	er	Maryland Casualty			
filed w filed w in Hyg	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai				
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	2	Harry Leon Ingle	Helen B	radt				
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1-	b. Mailing Address (Street and Number or Rura					
and 2 Healt tem 2			4502 Willow View St. 1 of Disposition (Name of		, MD 210/4 c. Location - City or Town, State			
mol		1 X Burial 2 Cremation 3 Removal from State Dulant 4 Donation 5 Other (Specify)	of Disposition (Name of early crematory or other place) ey Valley 20:	23, 12	Timonium, MD			
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signate of the real Service Technology			- 11 T			
a a a e e e		Bryan w. Clary	22. Name and Address of Facility Lemmon Funeral Hor 10 W. Padonia Road	ne of Dula 1 Timoni	iney valley, inc.			
		23a. Part 1. Enter the disease or complications that caused the death. Do shock, or heart railure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Interval Between			
h_sici_n Medical		Immediate Cause (final disease or condition resulting in death)	litis		Onset and Jeath			
Examiner		Due to (or as a consequence	e Oij.					
# T	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s olj.					
and transi	xam	Cause (Disease or injury that initiated events resulting in death) Last	201					
ords, P.O. Box 68760 Street requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical E	Testiting in death) East	, orj.					
7760 ficate by g physic as the b	/edi							
x 68	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 1	ath 3 Ectopic pregnancy		23d. Date of delivery			
Box death c the atten hed for u	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Unknown			Month Day Year			
P.O. that the ned by the detach		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?			
IS, I	Completed by	Hypercholesterolem	ia	1 🗆 Yes	2 II No 3 ☐ Probably 4 ☐ Unknown			
Records, The law requires ate has been sig	plet	thy po thy roid		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
//tal Reco /sician: The law r s certificate has b //lirector, page 2 s	l lie	1, ,		performe				
ician: certific	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	k only one)				
Phys rthis eral dii	<u>ان</u>	27. Manner of Death 28a, Date of injury 28b.	Outpatient 3 DOA 4 Nursing Ho	me 5 Residenc 28d. Describe how i	e 6 Other (Specify)			
ISION OF VITAL Attending Physician: ar death. ector: After this certific by the funeral director,	icate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury work? M 1 Yes 2 No	200. 20001130 11011	nary occurred			
Division of Vital tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director.	Certificate:	3	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)			
pital o		CO. C. of St. 1 Miles						
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check check only one) Certifying Physician: To the best of my knowledge check only one) Certifying Nurse Practitioner: To the best of my knowledge check only one)	or investigation, in my opinion, death occurred at	t the time, date and p	lace, and due to the cause(s) and manner stated.			
To th withir To th	2	29b. Signature and title of certifit	29c. License number		Date signed (Month, Day, Year)			
		· llu	D5485	5	July 19, 2012			
1HX		30. Name and address of person who completed cause of death (Item 23a)	(Type Print) Anna - D- D-1	Odon	for MA 21112			
Sta	te_	31. Date filed (Montin Day, Year) 32. registrar's Signature	Tillingoes Kar	1 Cour	101 (100) 0-1110			
Registi		111 2 4 2012 Server S.	garle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Month Physician/ Anna H. Jenkins 18. 10:20 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gildhrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 09/03/1919 Maryland 215-22-8150 Director 1 M 2 X F 92 Usual Residence of 27 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Madical Examiner must be notified at Pege 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-f showing or other treumatic event, the Machail Extensine must be notified at. Director 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🌠 No Maryland Harford County Forest Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 United States 1713 Landmark Drive, Apt. 2G 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 x Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William Perry Chesshire Ada Mae Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Beretta Way, Bel Air, Maryland 21015 Martha Hite (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pege 1
Department of Important: If it eny Injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/2012 Evans Funeral Chapel Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3. Newmort Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses scan of John 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 L Ectopic pr in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 After this certification 25. Was case referred to medical 8 26. Place of Death (Check only one) xaminer? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence မြ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending death. il Director: A 07/17/2012/0300AM 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1713 Lanchank Dr. # G Farres Hill M 2165 filled in by within 24 hours at To the Funeral D completely filled i #G Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or D0071187 Name and address of person who completed cause of death (Item 23a) (Type, Print) #405, Balthure, MD 21204 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Johnson Month Dorothy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice @ Northwest Hospital Randallstown 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days 217-24-9012 Director 1 □ M 2 💢 F 83 Yrs. July 23, 1928 Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director N/A Baltimore 1X Yes 2 □ No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 North Catherine Street 21223 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 halth and Mental Hygiene. 27 is marked other than "n r traumatic event, <u>the Med</u> Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Technician Johns Hopkins Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Seabron Brooks Pearl Brown 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haywood Johnson, Jr., Son 2680 West Park Drive Gwynn Oak, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 107/21/12 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage Dementia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of) the attending physician and hed for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death eral **urector**. Atter this certificate has been signed by the silled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 N 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier no Rajapakse mo D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSEG PALLE MD 792.5 Smith. Put 2935 Smith AV 5203

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State Registrar 2. Reginal r's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ Month Thomas E. Johnson July 22 M 8:43 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Hospital Prince George's Fort Washington Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. (Month, Day, Year) 1 x M 2 🗆 72 V<u>irginia</u> Director 231 50 5315 Dec 27, 1939 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant! If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2XX No Maryland 1 Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13330 L'enfant Drive 20744 United States ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Specify: Black Specify 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates 1963-1990 the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army Col Military other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cerelia Allen Louis Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13330 L'enfant Drive, Fort Washington, MD 20744 Canta S. Johnson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington, Virginia Arlington National Cemetery (unk) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria W01227 21. Sign Jure of Funeral Service Licensee Ferry Road, CLinton, MD 20735 23a. Reft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph, i.i.n. disease or condition Morby Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? a e has been signed by the atterpage 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an labe autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificale I completed filled in by the funeral director, page Yes 25. Was case referred to medical Be examiner? Hospital 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending injury 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1005605) (h X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arvind Narasimhan, MD 11711 Livingston Road, Fort Washington, 20744-5164 31. Date filed (Month, Day, Year, Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

AMEND PI LINE B PER MD G929 7/24/12 TRT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ gay 20 Yea CHARLES JONASSON JULY 12:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-09-1787 Director 1 🕱 M 2 🗆 F 94 Feb.13,1918 MD Usual Residence of Decedent 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified MD Baltimore Essex 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 223 North Marlyn Avenue 21221 USA death 12. Was Decedent Ever in U.S 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced If Yes. Give White "natural" Completed Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the Truck Machinist Beth Steel and Mental Hygie is marked other 8th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter C. Jonasson Mary Braunbart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or over Shirley Silverthorn /daughter 1329 Bennett Place Belair MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Cemtery 7/12/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Connelly Funeral Home of Balto. MD Essex 21221 Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) enter to there Medical Due to (or as a consequence of): Examiner CHRONIC RENAL INSUFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably \4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed? 2√ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 ☐ Yes 2 ☐ No death. Investigation Accident after death ⊒ Acciden ⊒ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

comple only one) the 29b. Signature and title of certifier ρ 29c. License number 29d. Date signed (Month, Day, Year) 03225 July 10,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) State Registrar

J3AY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23392 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2012 Gwendolyn V. Jackson 0355 Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1716 N. Dukeland Street Baltimore 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 10-15-73 Min Months Davs Hours Country **Director** 215-86-4922 1 ☐ M 2 🗓 F Yrs MD 38 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö and 2 should be filed within 72 hours after death with the Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 1716 N. Dukeland Street 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12, Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. African 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: American 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Diamond Cab Co NA <u>Dispatcher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gerald Joyce L_{\bullet} Jackson-Gunthrop Α. Jackson injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 N. Dukeland Street Baltimore, Maryland 21216 Tifani N. Jackson-Sister Department of Health
Important: If item 2
any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 07-27-12 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) ō in the past 12 months? Month Pregnant at time of death Unknown Day Year the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? the Funeral Director: After this certificate impletely filled in by the funeral director, pag Yes To the Hospital or Attending Physician: 25. Was case referred to edical Be 26. Place of Death (Check only one) Hospital 2 🗹 No 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 Yes 2 No 1 Natural 5 Pending injury after death, Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2

State Registrar

Physician Medic Examin Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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n/ al	T. Decedent's Name	e (i ii st, iviidale	(ons	tun	ce	J	ung	161	luH-	Month TUY	Day	2 0 1 2	3. Time of Death		
er	4a. Facility Name (if	not institution		et and number)	e Ce	nti	4b. City,	Town, or Lo	cation o	of Death		4c. Count	y of Dea	ath		
	5. Social Security No. 215–28–6		6. Sex		ge (In yrs. la	ist birtho	Months		f Under Hours		Date of Birth Month, Day	(ear) 931		rthplace (State or Foreign Suntry) RYLAND		
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Completed by Funeral Director	1 Never Marr		ried	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	X No		If Yes, spec	ify Cuban, I	Mexican	, Puerto Ric	an, etc.)		ack, Whit			
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To Be	17. Father's Name (i	First, Middle, L	Last)					18			irst, Middle, Ma	aiden Surnan	ne)			
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	MICHAEL J			-	SON		viailing Address 8287 BH	'						D. 21236		
17.5	20a. Method of Disp	oosition Gremation	3 □ Re	moval from State	20b. P	lace of E	Disposition (Nan crematory or o	ne of ther place)		Date 7-28-2	9 2		- City or	r Town, State		
	21. Signature of Full	neral Bervice I	icensee	A										E OF BEL AIR		
	23a. Part) Enter the disease, or comb lication, that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on, one caus on each line. Approximate Interval Between Onset and Death of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on, one caus on each line. Approximate Interval Between Onset and Death															
	Due to (or as a consequence of): Clostridium difficile Colits															
Examiner	Sequentially list co if any, leading to in cause. Enter Under	nmediate rlying	Due to (or as a consequence of):													
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Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b, Was decedent in the past 12,1		oregnancy						23d, Date of delivery Month Day Year							
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ed by F	Part II. Other signif	icant condition	ons contri	buting to death	but not resi	ulting in t	the underlying o	in Part	l.	23e. Did toba	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
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3e C	25. Was case referre	ed to medical		,				26. Place	of Deat	th (Check on	1 🗌 Yes 2 ly one)	No]	1 Ye	s 2 🗡 No		
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icate	1 Natural 2 Accident	5 Pendir Investig	gation	(Month, Da	ury 28b. Time of 28c. Injury at work? M 1 □ Yes 2 □ No 28d. Des						I. Describe how	scribe how injury occurred				
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. City or Town, State)									ıral Route Number,							
Medica	29a. Certifier 1 (Check 2 only one) 3	Medical E	xaminer	an: To the best of On the basis of ractioner: To the	examination	and/or i	nvestigation, in	my opinion, e	death oc	curred at the	time, date and	place, and du	ue to the	cause(s) and manner stated.		
	29b. Signature and	title of certifier	1	170	ons		290	License nu		91	29	d. Date signe	Z S	th, Day, Year)		
	30. Name and addre	imp	who com	20 13.	enso	n f	pe, Print)	٠,	130	ultin	י פינור	Mar	yla	nd 21227		
e r	31. Date filed (Monti	h, Day, Year)	4 20	32. Re	er's Signat	ure	Back	,				7		/		
				- July		-	7									

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23394 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Year 3,63 mer Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 - F Months Davs Hours Min (Month 218-14-2692 87 Director Baltimore, MD Nov. 30. Usual Residence of Decedent show 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Parkville MD Balti more 1 ☐ Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1704 Wycliffe Avenue 21234 United States should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Y Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Welder Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry Krause Anne Miller other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Margaret Krause (Spouse) 1704 Wycliffe Avenue Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State July ö Moreland Memorial Parkville, Maryland injury 4 Donation 5 Other (Specify) 2012 Park 21. Signature of Funeral Service License 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services 88 00 Harford Road Parkville, Maryland 21234 any 23a. Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician if for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ☐ Yes ∠ L ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has bage 2 s performed After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) <u>|</u> 1 🗌 Yes 2 1 No 1 1 Inpatient 2 -ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours area. ____ne Funeral Director; A Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 3 4359 (OH,O)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

2 4 2012

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32. Registrar's

12-05163 Carl Bruce Knox, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 23395

	1- For State Certificate of Death Reg. No.											
Physicia	an/	1. Decedent's Name (First, Middle,Las	(First, Middle,Last) 2. Date of Death							th Day Yea		3. Time of Death
edical Exami	ner		Bruce	Kr	nox	Jr.			July 9, 2012			1432 hrs
		4a. Facility Name (if not institution, given 3417 University Boulevard				4b. City, Town, or Location of Death Kensington						
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Funeral Director				55		Months Day		Min.		10,1957	Foreig	n untry)Maryland
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after	by F	3 Widowed 4 Divorced	If Yes, Give Year 197	5-77		es 2X No				Specify:		
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MD 12 sho th and 127 is		James C. Powell	/ Cousin		171 Gr	een Ba	y Terr	r.,	Sunris	e Beach,	MO	65079
Te, land Theal		20a. Method of Disposition 1 Burial 2 XXCremation 3	Domougl from State	cremat	ory or other	on (Name of ce			Date	20c. Location -	City or	Town, State
Pages eent of		4 Donation 5 Other Specify		Ches	apeake	Crema	tory (07/2	1/2012	Belts	svil	lle, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33s or 28s-f show any injury or other traumatic event, the Medical Examiner must he notified at once,		21 Signature of Funeral Service Licer		82	22. Nam	ne and Addres	s of Facility	d Cr	emation	n Servic	25	
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Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea		death. Do no	ot enter the	mode of dying	, such as car	rdiac or n	espiratory arr	est, shock, or hea	rt	Approximate Interval Between Onset and
Examiner	ĺ	Immediate Cause (Final disease a. or condition resulting in death)	Atherosclerotic Car		lar Disea	se complic	ated by H	lyperth	nermia			Death
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Box 687 e death certifi the attending ed for use as t	Physiciar	1 Yes 2 No 9 Unknown	·	ordeath t	Other	(Specify)						
O. Bo nat the de-		Part II. Other significant conditions	contributing to death but	not resulting	g in the und	erlying cause	given in Part	i I.	23e. Did to	bacco use contrib	oute to t	he cause of death?
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of Vital Records, P. og Physician: The law requires th ther this certificate has been signe meral director, page 2 should be d.	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpatient 3	DOA	Other4 I	Nursing I	Home 5	Residence 6	Other:	Scene
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Division Ial or Attendia Is after death. I Director: A led in by the fu	tific	3 Suicide 6 Could not	be 28e. Place of Injury	- At home, fa	arm, street, f	factory, office t	ouilding, etc.		or Town, S	tate)		al Route Number, City
Spital Jours	Certification:	4 Homicide determine	d (Specify) Multi-F	amily Ap	t.			34	17 Universi	ty Boulevard #3	03, Ke	nsington, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – trans		(whom only	ian: To the best of my kno ::On the basis of examina	_								
To t withi To t	Medical	29b. Signature and title of certifier	and manner stated.			29c. Licens				29d. Date signed		
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1		30. Name and address of person who	completed cause of dooth	(Item 22a)						2., 10, 20		
OX'V			tant Medical Exami	. ,	W. Baltii	more Stree	et, Baltimo	ore, ME	21223			
	ate	31. Date filed (Month, Day, Year)	32. Registrary S	ignature	4	<u> </u>						
Regist		nn 2 4 2012 /	Charles S.	XIVEN	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DIANA LEE KILDUFF JULY 19,2012 9:45A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5123 FORGE ROAD PERRY HALL BALTO. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 220-50-0273 66 **Director** 1 🗆 M 2 🛣 F Yrs. 4-23-1946 MARYLAND Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No MD BALTO. PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral USA 5123 FORGE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working PERRY HALL HEATING & life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OFFICE MANAGER AIR CONDITIONING alth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and Monta Important I frem 27 is marked any injury or other traumores မ DANIEL LIVIO MARGARET DEFAZIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERARD D. KILDUFF **SPOUSE** 5123 FORGE ROAD PERRY HALL, MD. 21128 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Toremation 3 Removal from State ATLANTIC CREMATORY 7-23-2012 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servio Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM. First Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final stan Physician/ una Conce 1 disease or condition Medical resulting in death) a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 Yes Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2. No Other: ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Suicide

burial-transit physician death certificate be Box 68760 the attending p signed by the a ld be detached f P.O. Division of Vital Records, page 2 should certificate has filled in by the funeral director, After this Certificate: Hospital or Attending 24 hours after death. Director: within 24 hours a

To the Funeral C Medical

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Maryland 21215-0036

altimore,

5 V State

Registrar

of person who completed cause of death (Item 23a) (Type, Print) uite 31. Date filed (Mon

Investigation

determined

6 Could not be

4 Homicide

29a. Certifier

(Check

only one) 29b. Signature and title

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Day, Year)

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Ba Ho. Mo. 2123

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2012 02:45AM 21, July Joseph G. Loiero /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel If Under 24 Hrs. ar)
1933
9. Birthplace (State or Foreign Country)
Baltimore
Maryland Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□F 213-30-2937 Feb. 04, Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland | Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or death with must be 1211 Mill Creek Road 21047 U.S.A.

14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No 1953— If Yes, Give Year or Dates: 1955 1 ☐ Never Married 2 Married 5-0036 6 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 than Elementary/Secondary (0-12) College (1-4or 5+) Printing Owner - Braemar Press and Mental Hygic Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be and 2 should be a ၉ Pietro Loiero Mary Giralico 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Mill Creek Road, Fallston, Maryland 21047 <u>Mrs. Nancy Loiero (Spouse)</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 24, 2012 Bel Air, Maryland Bel Air Mem. Gardens 21. Signature of Funeral Service Licensee Jeffrey R. Testerman and Address of Facility
Evans Funeral Chapel & Cremation Services

Evans Funeral Chapel & Cremation Services lectuman $(M0\bar{1}543)$ 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) month **Physician** Lung Cancer /Medical Due to (of a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): P.O. Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) a∏IJnknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by monan 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law 24a. Was an 2 No 1∐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation or Attending 1 Naturai Injury 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospitai 1 'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. Medicine 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/21/1 20661 lichendly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Notation (Month, Day, Year) 500 the sapeake

Registrar DHMH 17 Rev 1/2001

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DIET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 Margaret Elaine Lenz 4:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Genesis Ctr. Dorchester Cambridge 8. Date of Birth
(Month, Day, Year
May 15, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Days Hours Min. 1 □ M 2 🔀 F Pennsylvania Director 1928 196-22-1893 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo MD Cambridge Dorchester 10f. Zip Code 10g. Citizen of What Country? Funeral 5641 Clifton Woods Drive 21613 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 X No Specify: If Yes. Give than "natural", Completed 3X Widowed 4 □ Divorced White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Own Home Homemaker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve ည Sophia Hazuda Frank Kasinec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5641 Clifton Woods Drive Cambridge, MD 21613 Mrs, Deborah A. Roe (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/21/2012 Baltimore, Maryland Gardens of Faith Cem. 4 ☐ Donation 5 ☐ Other (Specify) L. Neise 21. Signature of Funeral Service Licensee, Micheel Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

5 49 4 Immediate Cause (Final Physician/ ompati A disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) g physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death g Unknow 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 Hospital: Other: ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Watural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work' within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu 2 No Accident
Control
Contr 1 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner 70 he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

601 31. Date filed (Mo person who complete

4 RR

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

d cause of death (Item 23a) (Type, Print)

32. Registraris Signature

29d. Date signed (Month, Day, Year)

ambr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 2012 5:20 A M Lilly Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Upper Chesapeake Health Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 213-70-4765 Director 1 💢 M 2 🗆 F June 12,1955 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location must be notified at Director 28a-f Harford Forest Hill 1 Yes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2139 Mardic Drive 21050 United States ral", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+)
4 Years 12 Years Defense Dept. Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty Shaver Gregory Joseph Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 1825 S. Hanover Street Baltimore, Maryland Mr. Gregory H. Lilly (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith Cem 7/25/2012 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee Dennis Garrol 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on enabline. Approximate Interval Between Immediate Cause (Final et and Dea Physician/ MOD disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Day to for as a not recommon of If any, leading to innedicause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by luno viscesse 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) the Hospital o Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) Riverelliner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHESAPEAKE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 Deborah Liaci 2012 5:50P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Anne Arundel Harwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months (Month. Day, Year) Hours Director 213-80-5232 1 M 2 X F 51 11/06/1960 Virginia r than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at filed within 72 hours effer death with the Merylend al Hygiene. 3 other than "natural", or items 23a or 28a-f eho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie 1 ☐ Yes 2 X No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7219 Judy Road 21060 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes 2 🔯 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) System Analyst Naval Academy t. Page 1 end 2 should be filed with thrent of Heelth end Mental Hygler rtant: If Item 27 is marked other 1 jury or other traumatic event, th 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Livia Sain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 Mrs. Livia Liaci / Mother 7219 Judy Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page Depertment o important: if any injury or 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 07/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service License MO1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) uarian GRAI Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): es the burlel-trensit To the Hoepital or Attending Phyelcian: The lew requires thet the deeth certificete be executed within 24 hours efter death.

To the Funerei Director: After this certificete hes been signed by the attending physicien end completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trens Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manner of Centh Certificate: 28h. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 ☐ Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b, Signature and title of certifier ame and address of person who c leted cause of death (Item 23a) (Type, Print) 2/

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Julius Clyde Lilly, Sr. 07 20 2012 11:18P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1269 Sleepy Hollow Road Severn Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Director 217-24-8022 1 🛛 M 2 🗆 F 84 06/16/1928 West Virginia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Severn 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1269 Sleepy Hollow Road U.S.A. 21144 12. Was Decedent Ever in U.S. Armed Forces?
1

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 5 Completed by 1 Never Married 2 Married X Yes Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 XWidowed 4 ☐ Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Owner Ice Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ pe 1 Lilly Oliver Cromwell Uva Meadows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Mrs. Debra Furlong / Daughter 1269 Sleepy Hollow Road Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Glen Haven Mem. Park 07/24/2012 Glen Burnie, MD 21. Signature of Funeral Service Licens MO1479 22. Name and Address of Facility $\,1\,$ 2nd $\,$ Avenue $\,$ SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the texth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final liver Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transif Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending ph d for use as t IÉ FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year detached 9 Unknown Unknown P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: 2 No Other: 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manker of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending work? 1 🗌 Yes 2 No Accident Investigation the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) $\mathcal{M}()$ 30. Name and address of pers ise of death (Item 23a) (Type, Print) Landmark Drive, Glen Burnie, mn 2106 807

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 3:58 AM Jul Betty Jane Lacoste 9 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hospital of Baltimore Baltimore Baltimore City . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 M 2 5 F 05/02/1932 215-28-2988 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Elkridge MD Howard 1 Yes 2 K No 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code "natural", or items 23a o Funeral 21075 6241 Greenfield Rd., Apt. 204 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc acoste þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) alth and Mental H 27 is marked of ir traumatic ever ည Marie W. Rorhman Thomas Miles Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Kuegler - Daughter 6241 Greenfield Rd., Elkridge, MD 21075 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donayon 5 ☐ Other (Specify) Air Mem'1 Gardens 07/21/2012 Bel Air, MD of Funeral Service License Schimunek Funeral Home, Signatu 22. Name and Address of Facility 610 W. MacPhail Rd., Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ renal Pailure Acute disease or condition days Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signal. Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burial the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant in the past 12 months? Day Year Pregnant at time of death g Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ encephalo party Completed 1 Yes 2 No 3 Probably 4 Unknown disease coronary artery 24a. Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2XNo 1 🗌 Yes Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗆 Yes 2 🗔 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) MD D 70334 . 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Belvedere Ave, Baltimore MD 21215

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State Registrar 240

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Physician/ Augustus Madison, Sr. *"*"/"11/2012 8:30a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9366 Pep Rally Lane Waldorf Charles If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Days Months Hours Min. (Mazth 18/1943 577-56-0199 Washington, DC **Director** 69 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director 1x Yes 2 □ No MD St. Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9633 Pep Rally Lane 20603 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced B1ack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis E. Madison Paralee Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Madison, Jr./Son 9366 Pep Rally Lane Waldorf. MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 7/19/2012 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Fu eral Service Hiensee 716 Kennedy St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy sate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 § Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 Q:N Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural
2 Accident
3 Suicide work? injury 5 Pending after death. 2 🗆 No Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

		For	State of	f Marylan		artment of H		Mental Hy	giene 2 n	112	23404
		State Registrar			Cei	rtificate of I	Death		Reg. No.	1 4	
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death ms 2	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Nas Decedent of H f Yes, specify Cuba		pecify Yes or No		e - Americar	n Indian,
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination that he must be multified and once.	ρ	1 XNever Married 2 Marri 3 Widowed 4 Divorced	ied Armed Fo ied 1 ∐Yes If Yes, Gi Year or D	2 XNo ive		r Yes, specily Cuba 1 ∐Yes 2 XINo	Specify:	o Alcan, etc.)	Specify	k, White, etc	White
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	edical (ng Physician: To the Examiner: On the l								
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		30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,	Print)					
O A		DON H. YABLONG	WITZ M.D	811	6 GOOD	LUCK RD,	#300, L	ANHAM, N	4D 2070	5	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 2012 Physician/ 22 7:55 Рм McAlee Sameeran Y. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase 4700 Davidson Drive 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** Hours 350-28-7129 1 🗌 M 2 🗶 F **Director** Nov 11, 1934 Iraq 77 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10h County notified at Director 1 🗌 Yes 2 🔀 No Chevy Chase Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ ems 23a or r must be r Funeral United States 20815 4700 Davidson Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Examiner 2 **X** No 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates ö þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Specify: Caucasian "natural" 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Art Artist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ျ Elizabeth Maksud Yonan George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other tract Chevy Chase, MD 20815 4700 Davidson Dr. Schindler / Sister Yvette 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 7/25/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Signature of Funeral Service Liger MO1251 23a. Part 1. Enter the alsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 X No Pregnant at time of death 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a Was an death? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27 Manner of Death Certificate: injury 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by t determined Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

5454 Wisconsin Ave. Ste 1300

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Smith
31. Date filed (Month, Day, Year)

2 4 2012

D33293

July 23, 2012

Chevy Chase, MD 20815

PI:	ease T	ype or Print in Black
		State of Maryland / D
1- For State Registrar		
1. Decedent's Na	me (First, N	vliddle,Last)
Steven	Ray	Myers
	1- For State Registrar 1. Decedent's Na Steven	1- For State Registrar 1. Decedent's Name (First, M

k Indelible Ink. Ensure All Copies Are Legible. Department of Health and Mental Hygiene 2012 23406

		1- For State Certificate	of Death	Re	eg. No.	IL LOY
Physician/ Medic Exami	cal	Decedent's Name (First, Middle,Last)		2. Date of Deat Month July 20, 20	th Day Year	3. Time of Death 1419 hrs
		4a. Facility Name (if not institution, give street and number) 10324 Gruber Road	4b. City, Town, or Location of Deal Keymar	th	4c. County of Death Frederick	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours Mi	in	Co	thplace (State or Foreign buntry)
		215-70-0070 1X M 2 F 56 Y	rs.	June 7	, 1956 Was	shington DC
and show any ace.	_	10a. State 10b. County 10c. City, Town or Loc MD Frederick	ation Keymar			10d. Inside City Limits 1 Yes 2 No
with the Maryland is 23a or 28a-f sho e notified at once.	Director	10e. Street and Number	10f. Zip Code	11	0g. Citizen of What Cou	
n with th rms 23a (Funeral D		21757 Vas Decedent of Hispanic Origin? (§ f Yes, specify Cuban, Mexican, Puer		United Sta	tes ican Indian, Black,
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or teems 23a or 28a-f shi c event, the Medical Examples, to the notified at once	by Fun	1 X Yes 2 No	Yes 2 X No specify:	to 14001, 0101	Specify: Cau	casian
72 hours :			ent's Usual Occupation (Give kind of most of working life. DO NOT use re		16b. Kind of Business/	Industry
5-0036 led within 7 Hygiene. other than	Completed	12 Carp	enter	ne (First, Middle, M	Construc	tion
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Raymond Randolph Myers	Clara	Ruth J	Jones .	
e, MD 2 1 and 2 shoul Health and M item 27 is m	2				ntown, PA 1	7022
2		1 Burial 2 X Cremation 3 Removal from State crematory or		Date	20c. Location - City or	
Baltimore, permit Pages 1 ar Department of Hee Important: If the		4 Donation 5 Other Specify Final Journ 21. Sonature of Funeral Service Ricensee 22	ney Crematory 7/ Name and Address of Facility Ding Home Cremati Everly L. Heckrot	024/2012 on Servi	ce P.O. Bo	Maryland x 784
ய உத்தத் Physician	Н	23a, Part I, Enter the disease for complications that caused the death. Do not enter t	verly L. Heckrot the mode of dying, such as cardiac o	te, P.A.	Clarksvil	Approximate interval
/Medical Examiner		failure. List on one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of):	clerotic Cardiov	ascular	Disease	Between Onset and Death
	Ļ	Sequentielly list conditions,				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.				
ecuted and and		d	~020 0 2 12 cm			
760, ficate be executed g physician and the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			23d, Date of delivery	
× 68760, th certificate b tending physic	ician/	past 12 months? 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregress Other (Specify)	nancy	Month (Day Year
that the death certificate by the attending detached for use as!	Physici	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S, P.O pures that ti m signed by lid be detac	ed by				2 No 3 Prol	
Division of Vital Records, talor Attending Physician: The law requires after death. 12 Director: After this certificate has been seled in by the funeral director, page 2 should	Completed			24a. Was a autop perfor	sy prior to rmed? death?	stopsy findings available completion of cause of
tal Rec	Be Co	25 Was case referred to medical examiner?	26.Place of Death (Checi	k only one)		
f Vital Physician: er this certi	2	examiner / 1 X yes 2 No			Residence 6 X Other	Scene
ion of tending Pi eath. :or: After the funera	ation:	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	200. Describe (ion injury occurred	
Division of part of the strength of the strength our after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	28f. Location (S or Town, S	treet and Number or Ruitate)	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hosp hal or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	edical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurrence) 2 Medical Examiner: On the basis of examination and/or investigation.				
T ¥ ii	Me	29b Signature and title of certifier	29c. License number	DOME	29d. Dete signed (Mo	nth, Day, Year)
Page 12		Thinker III. Ring The see	O.C.M.E.		July 21, 2012	
TOLV	ate	Theodore M. King, Jr., MD. Assistant Medical Examiner 31 Date filed (Month, Owy Year) 32 Registr/ & Signature	900 W. Baltimore Street, Ba	altimore, MD 2	1223	
Regist		31 Date filed (1/07/17, Cary (29/1)) 32 Registry's Signifure ORIGIN	IAI			
COMMAND A CO., 40%	CITY .	ORIGIN	rs.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of M	aryland / Depa <i>Cei</i>	artment of H	ealth and Me D <i>eath</i>		ene 2012	23407
			Registrar 1. Decedent's Name (First, Middle,	Last)		0.0		Date of Death		3. Time of Death
	Physicia		CADMAN	1	M	APP	-	Month ULY 16.	Day Year 2012	7:15a ^M
7	/Medic		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death	OHI IO	4c. County of Deat	
	Examin	er	SPRINGBROOK CE			SILVER	SPRING		MONTGOM	ERY
	Funeral		5 Social Security Number	S. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year		Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		110-44-2715	1 X XM 2□F	79 Yrs.	Months Days	Hours Will.	4-16-19	933 WE	ST INDIES
	P.	-	Usual Residence of Decedent		10c. City, Town or Lo	ention				10d. Inside City Limits
	show	_	MD. 10b. County PRINCE	CEOPCE	LAURE					1 TYes 2 No
	8a-f	Director		GEORGE	INCRE			10	g. Citizen of What Co	untry?
	with the	금	10e. Street and Number	GT 77 //1/0		10f. Zip Code	, i			,
	s 23g	rai	7903 ORION CIE	CLE #149	Ever in IIS 13	2072	ispanic Origin? (Spec	ifv Yes or No-	USA 14. Race - Ame	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notilised at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Amed Forces	No	If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	ćan, etc.)	Black, Whit	e, etc. LACK
Ö	2 hou		15. Decedent's	s Education	16a. Dece	dent's Usual Occup	ation		6b. Kind of Business	Industry
21215-0036	within 72 ene. than "na he Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	during most of working f)	'		
212	d with	E	-6-	-0-		HANIC			AIRCRAFT	
	al Hyg	Be C	17. Father's Name (First, Middle, L.	ast)			18. Mother's Name		laiden Sumame)	
ylaı	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ha M	70	SAMUEL MAPP	in (Time Print)	10b Maili	na Address (Street	CLARA Nand Number or Rural		City or Town, State,	Zip Code)
Maryland	ad 2 sh lith and 27 ls n r traun		19a. Informant's Name/Relationsh JEAN MAPP (WIFE				CIRCLE #14			
ore,	of Health of Health if Item 27 or other tra		20a. Method of Disposition 1 X Burial 2 Cremation	3 □Removal from State)	matory or other place	1		Oc. Location - City or	
Baltimore,	permit. Pages Department of t Important: If Ite any injury or of		*4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecify)	KING MEMO				BALTIMORE,	
Ba	Depa Impo any ii		1 tout	D.Au						ÝLAND 21217
	Physician		23a. Part I Enter the disease, or o shook, or heart failure. List o	only one cause on each	d the death. Do not en line. DPULMONARY		ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a	s a consequence of):	ARREST				
*	Lxammer	er	Sequentially list conditions, if any, leading to immediate	D	RAL VASCULA s a consequence of):	R ATTACK				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events		TES MELLITU	S				
760,	be executed sician and burial-transit	cal Ex	resulting in death) Last		s a consequence of): TENSION					
687	¥ %			0						
.O. Box (death cer e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	y		23d. Date of de Month	livery Day Year
0	res that the signed by be detact	by	Part II. Dther significant condition	ns contributing to death	but not resulting in the t	underlying cause giv	ven in Part I.		es 2 □ No 3 □ P	o the cause of death?
ord	w requir been si should	ted								utana, findings available
Vital Records,	The lar	Completed						24a. Was an autops perform	prior to death?	utopsy findings available completion of cause of S
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death			
of	Physi this o	2	1 Yes 2 No	1 Linpa		nt 3∐ DOA	Nursing Hon		ence 6 □Other (Special own injury occurred	ecity)
n	ding F	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending		ay Year) 200. Tille	Wo		00. 00001100 110	, and any occurrence	
Sic	Attending Physician: r death. ector: After this certifici by the funeral director, i	Icat	2 Accident investig	not be 390 Place of I	njury - At home, farm, s			8f. Location (St	reet and Number or F	Rural Route Number,
Division of	at or A after 1 Direct d in by	Certification:	4 Homicide determ	building,	etc. (Specify)			City or Towr	n, State)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1X Certifyin (Check only one)	g Physician: To the bes Examiner: On the basis and manner	of examination and/or i	th occurred at the tr nvestigation, in my	me, date and place, a opinion, death occurre	d at the time, d	ate and place, and di	e to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	1		29c. Licens		2	9d. Date signed (Mor	
				100		DOC	067092		JULY 18	, 2012
\rangle			30. Name and address of person DR. WEIHAN WA	who completed cause of ANG, M.D. 1	death (Item 23a) (Type 5245 SHADY	GROVE RD.	SUITE 130	ROCKVI	LLE, MARY	LAND 20850
	St Regist	ate rar	31. Date filed (Month, Day, Year)	12 Regis	strar's Signature	Red				
			·	/	- 1					

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Zc 12 00 30 AM Mitchell James Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death urroll erroll Hospital Center Westminster 8. Date of Birth (Month, Dav. 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 217-76-3599 1 M 2 D F 10/28/1964 MD 47 Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director item 27 is marked other than "natural", or items 23a or 28a-f so other traumatic event, the Medical Examiner must be notified 1 X Yes 2 No Sykesville Carroll MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21784 USA 6655 Sykesville Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married by ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BARC Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Patricia Monroe James Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or with Patricia Williams / Mother 327 Collins Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Dination 5 Other (Specify) On-Site Cremation 7.28.2012 Baltimore, MD John L. Williams Funeral Directors, 4517 Park Hgts Ave Baltimore, MD 21215 Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Vermonia disease or condition Medical resulting in death) Examiner Mounothorax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine respiratory facture Cause (Disease or injury that initiated events resulting in death) Last Ventilator and -tran: Due to (or as a consequence of) nding physician ar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year ed by the a P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chroniconstruction Pulmoney Discuse, Records, 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed en 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypernatremia, Metalatic Color Cancer has le 2 autopsy performed? **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1.X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MD D6908C 19 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA MD Carroll Hospital Center Wetmingter CHINTY

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nemott Physician/ 0149 obert July 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death The Johns HOPKins N/A Himore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-58-9667 **Director** 1 XM 2 □ F 61 March 7, 1951 California ms 23a or 28a-f show must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 X Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5601 York Road Apt. 302 21212 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 Widowed 4 X Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mansard Roofer Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Alan Nemoff Sally Bagget 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Eutaw Place Apt. 1013 Baltimore, MD 21217 Pamela I. Raspi, Fiancee 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/20/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Remeand Address of Facility Of Maryland, Inc. 29 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease en complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between eft hip fracture Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, hading to immode cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transi and Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the ald be detached for Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Pulmonary embolism Records, 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pulmonary disease 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 🔀 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☐ Natural 2 🔀 Accident injury 5 Pending work? 1 ☐ Yes 2 🔀 No 718/12 trpped over shoe OO PM Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Home 5610 York Road Apt 302 Baltimore MD 21012 Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie RES-000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N Orleans St. Baltimore MD 21287 MD State Registrar

W DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Phillips 06:00 A M Medical July 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timenium Stella Maris Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Country/Baltimore, Director 216-24-8524 1 X M 2 □ F 80 Dec. 06, 1931 Maryland Usual Residence of Dec 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the <u>Medical Examiner must be notified at</u> 10a, State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits Harford Maryland Fallston 1 🗌 Yes 2 🔯 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 805 Lynch Terr. 21047 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Carpentry Cabinet Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk. permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev pe Leon Phillips Lillian 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Phillips (Son) 3622 Ady Road, Street, Maryland 21154 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 28, 2012 Highview Mem. Gardens Fallston, Maryland Funeral Service Licenses Joffrey R. Testerman 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air
3. Namport Drive, Forest Hill, Maryland 21050 Signature (M01543)ELLLENOM Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Priysician Onset and Death disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician ched for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be: 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) THOMAS PHILLIPS Month Day page 2 should be detached 9 Unknown 9 I Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 😿 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To 1 ☐ Yes 2 🕱 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) HOSPICE Director: After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital c within 24 hours at To the Funeral D completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Dafe signedj(Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day,

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UNK UNK			tment of Health and Mental F ificate of Death	-lygiene	2012 234
Physician/ Medi	cal	registrar	neate of Death	2. Date of Death	
Exami		Sean D. Peartree		July 18, 20	
		4a. Facility Name (if not institution, give street and number) 2800 Wilkens Avenue	4b City, Town, or Location of Deat Baltimore	th	4c. County of Death
Funeral		Social Security Number 6 Sex 7. Age (In yrs. las		s. 8. Date of Birth	MMW/DD/YYYY 9. Birthplace (State or Foreign
Director		071-58-9970 1 MM 2 F 41	Yrs. Months Days Hours Ma	n. 4-29	-1971 New York
×		Usual Residence of Decedent			
I IOW an			own or Location		10d. Inside City Limits 1 Yes 2 No
viary land 28a-f show any datonce.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
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	Funeral	11. Marital Status 12. Was Décedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (S		14. Race - American Indian, Black, White, etc.
er deal	Fur	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	, , , , , , ,	Specify Black
2 hours aft "natural" Exemine	d by	nr Dates:	6a. Decedent's Usual Occupation (Give kind of a		16b. Kind of Business/Industry
hnn 72 ho e than "ns	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)	
5-003 led within Tygiene other th	omp	17. Father's Name (First, Middle, Last)	Cook 18 Mother's Nam	e (First, Middle, Ma	rast roud
21215-003 uld be filed with Mental Hygiene, marked other ti c event, the Med	BeC	Charles Davis &	Esdell	Pearl	re e
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyggene 7 is marked other than "natural", or items 23a or 28a-f sho ratic event, the Medical Examiner must be notified at once.	Į,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State, Zip Code)
and 2 sealth a term 27 traums		CSOCI DOVIS MOTHER 20a. Method of Disposition 20b. Pte	4209 Granzela Al	Date Pak	20c. Location - City or Town, State
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death w Department of Stealth and Mental Hygene. Important: If tem 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be		1 Burial 2 Cremation 3 Removal from State cre	ematory or other place)	77 720	R16 11.
altin mit. P partme portan ury or		4 Donation 5 Other Specify 21 Signature of Funeral Service Licencee	22 Name and Address Facility	Funeral	Service P.A.
		Carlon C. Dunfan	1701 Metullak Xt.	Balto.	W. 21217
Physician /Medical		23a. Part I. Enter the disease, or complication that caused the death, Do failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or	r respiratory arrest,	shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):			Cocket
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	dical	_	ME G9297/25/2012 JH		
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SCOF e law r e has t	фш			autopsy	ned? death?
Triffical to Page		25 Was case referred to medical	26 Place of Death (Check	1 X Yes 2 only one)	No 1 X Yes 2 No
Vital hysician:	To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 Ef	R/Outpatient 3 DOA Other Nursi	ng Home 5 R	esidence 6 X Other Scene
Division of Vital Records, P.O. Box 68760 ral or Attending Physician: The law requires that the death certificate b rs after death. 12 Director: After this certificate has been signed by the attending physical in the funceal director, page 2 should be detached for use as the but.		1 Notice (Month Day, Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe hor Subject motor	winjury occurred rcyclist involved in motor vehicle
Sio Atten or death rector: by the	cati	2 X Accident Investigation Jul 18 2012 2	238 hrs 1 Yes 2 No e, farm, street, factory, office building, etc.	accident	eet and Number or Rural Route Number, City
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	Suicide 6 Could not be determined (Specify) Roadway	· · · · · · · · · · · · · · · · · · ·		te) Baltimore, MD 21215
Division of Vital Records, P.O. Box 68760, To the Hoptal or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	cal C	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge.		due to the cause(s)	and manner as stated.
To th within To th comp	Medical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier	29c. License number		place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
		1/2 1/ 1/		DGME	July 19, 2012
	-	38 Name and address of person who completed callse of death (Item 23a	(1)		, ,
		Theodore M. King, Jr., MD. Assistant Medical Exam	miner 900 W. Baltimore Street, Bal	Itimore, MD 21	223
Sta Regist	ate rar	31 Date filed (Month, Day, Year) 32 Registrar's Signature	barker		
DHMH 17 Pev 1/200			ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death nt's Name (First, Midelle 2. Date of Death Month 3. Time of Death Physician/ erson **3:35A**M 2012 Medical Facility Name (if not institution, give street and num **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Nursing Baltimore 10me Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Director 1 🗌 M 2 🕦 28a-f shov 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number ō 10g. Citizen of What Country Funeral 23a items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ₩idowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha eamstress year Be ather's Name (First, 18. Mother ၉ permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. vindsor 30V Baltimore, 20b. Place of Disposito 20a. Method of Disposition n (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Fun ra Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition UNKNOW Cerebroyes when accident Medical resulting in death) Due to (or as a consequence of) **Examiner** Attech Fibrillation **じろころらいろ** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No be detached for Day Year Pregnant at time of death Unknown g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops performe After this certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 \sqrt{Yes} 2 \sqrt{No} 1 Natural injury 4 hours after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl of certifier 29d. Date signed (Month, Day, Year) D0059056 20 12 ddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar west

700

32. Regist ar's Signature

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St Belt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael terlman illian 2:20 PM 2012 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 601 60 09 463 Monl Omer 6 Social Security Number Sex Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Months Hours Min. **Director** 577-03-5446 94 1 □ M 2 [**X**F Yrs. Aug. 12, 1917 Georgia show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes XXX No ME Montgomery Rockville 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? ural", or items 23a or Examiner must be Funeral 6111 Montrose Rd. #426 20852 United States permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important; if item 27 is marked other than "natural", or items any injury or other traumatic event; the Medical Examiner mu once. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify White Specify 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Liquor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dan Michael Henrietta Witkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 315 Plymouth St., Silver Spring, MD Mark Perlman / Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 07/20/2012 Beltsville, MD Signature of Funeral Service Licenses Name and Address of Facility app Funeral and Cremation Services 33 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ lantin complications disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MD Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of burial-transi and MY20PM resulting in death) Last Due to (or as a consequence o signed by the attending physician Id be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy perform 1 ☐ Yes 2 ☐ No Yes completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) eriman, Lillian m examiner? Hospital 2 | No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending self-inflicted overdose 12 2012 UnKM 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of By City or Town, State) 6 4 f < 6 , Rockville 1 4 Homicide determined building, etc. (Specify) £426, Wome mD Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Number rectification of the best of my knowledge, and the commediation that cause and place, and due to the cause(s) and manner as stated. (Check 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 100060117 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Exc. Park, MD, 8600 Grangetowin Rd. 20816 31. Date filed (Month, Day, Year) 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Francis X. Pugh, Sr. 743 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO Peninsula Regional Medical CEATEL SAL 136414 Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) Director 215-32-1720 1 X M 2 □ F 80 June 24 1932 MD Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show enly injuy or other traumatic event, the Markel Evaniner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Baltimore MD Timonium 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2518 Lawnside Rd. 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Black, White, etc. ۾ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Asst. Attorney General Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Pugh Catherine Feeley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann M. Pugh/wife 2518 Lawnside Rd., Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/23/121 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Fundamental Service Lice (see 22. Name and Address of Facility Lemmon Funeral 10 W. Padonia Rd Home of Dulaney Valley, Inc. Timonium, MD 21093 Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Due to (or as a consequence of): Exami sician and burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the 98 attending p IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) signed by the at 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by cate has been sig ; page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 K No To the Hospital or Attending Prystotam, me, within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🛭 No မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 A Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Detailing Priysterian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Detailing Priysterian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Un D54807 w 7-17-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Sklisbury, Md. 21801 Agarwal Ramesh 31. Date filed (Month Day, Year) State barker Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stacey Lynn Pr		1- For State Registrar	Sta	ate of Maryla		artment of rtificate of		l Mental	Hygiene	Reg. No.	2012 234
Physician/ Medi	cal	Decedent's Name	(First, Middle	,Last)				**	Date of D Month		3. Time of Death
Exami	ner	STACEY 4a. Fecility Name (if		YNN			RICE		July 20,	2012	1244 hrs
		Carroll Hospital		, give street and rush	berj	1	b. City, Town, or L Vestminster	ocenon of De	eath	4c. County of Carroll	of Death
Funeral		5. Sociel Security Nu	mber	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year			Birth (MM/DD/YYYY	Birthplace (State or Foreign Country)
Director		220-84-	7786	1 M 2∭F	50	Yrs.	Months Deys	Hours	Min. 06/1	2/1962	MD
ź.		Usual Residence of E	Oecedent Ob. County		10c City	. Town or Locatio	20				40d Issido City Units
E MOM				DOT T	loo. City						10d. Inside City Limits 1 ☐ Yes ※※No
arylan Sa-f st	ctol	MD 10e. Street and Numb		ROLL		FINKSBU	10f. Zip Code			10g. Citizen of Wh	
th the Maryland 23a or 28a-f sho	Director	2525 BA	I.TTMOR	E BLVD.,	T.OT 29		2104	4.8		USA	
r death with the Maryland or items 23a or 28a-f show any	Funeral	11. Merital Status		12. Wes Dec	edent Ever in U.	S. 13. Was	Decedent of Hisp es, specify Cuban,	anic Origin?	Specify Yes or h	Vo- 14. Race	- American Indian, Bleck,
r death	FI	1 Never Married	_	1 Yes	2 XX No				erto Riceri, etc.)	White	
rs afte	à	3 Widowed 15 Decedent's Edu		orced If Yes, Give Year or Dates: ify only highest grad			Yes 2XX No 's Usual Occupation		f work done	Specify: 16b, Kind of Bu	WHITE
72 hou	Completed	Elementary/Secon		College (1-			ost of working life.			Tob. Nilla of Ba	arress irrouse y
036	dm			2		NI	JRSE			ME	DICAL
21215-0036 Jul be filed within 72 hours after death wi Mental Byggene marked other than "natural", or frems: c event, the Make Experiment bet		17. Father's Name (F	irst, Middle, I	ast)			1:	8.Mother's Na	me (First, Middle,	Maiden Surname)	
212 uld be Menta marke	To Be	JEROME 19a. Informent's Nem	e/Relationshi	p (Type, Pnnt.)	FIN	NE 19b. Mailing	Address (Street	SUE and Number	or Rural Route N	umber, City or Town	BROTMAN State Zip Code)
MD and 2 shot m 27 is aumatic	-	SUE BROTT		Mot	ther E					INGS MIL	
MOFE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland bort of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f the rother traumatic event, if a Notkel East Metrius be notified at one		20a. Method of Dispo	sition		20b. F		on (Name of ceme		Date		City or Town, State
Pages herit of ant: I		4 Donation 5	_		7.4		HEBREW (CEM O	7/23/201	2 REIS	TERSTOWN, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thingury or other traumatic event, the Man		21. Signature of Fune			1		ame and Address o	(5 1)			ROS., INC.
	_	23a. Part I. Enter the	dispase or o	complications that car	sed the death.	890	O REISTE	RSTOW	I ROAD.	PIKESVILI	LE, MD 21208
Physician /Medical		failure, List only	one cause	on each fine.				cii es calulac	or respiratory err	est, shock, of near	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Fit or condition resulting		e Narcoti Due to (or as a							Code
		Sequentially list condi		b							
	ulne	if any, leading to imm cause. Enter Underly (Disease or injury that	ing Cause	Due to (or as a	consequence of	·):					
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760, cate be e		IF FEMALE:		23a,27,	28a-f	er me,	931 9-12	12 si		23d. Date of	dollivora
687 ertifica ding pl		23b. Was decedent pr past 12 months?	egnant in the	1 Live bir	th	2 Feta	al death 3	Ectopic pre	gnancy	Month Month	Day Year
Box 687 s death certific the attending of	Physician/	1 Yes 2 X No	9 Unkr		ant at time of dea vn	ath 5 Oth	er (Specity)				
that the de ted by the detached f		Part II. Other signific	ant condition			sulting in the und	lerlying cause give	n in Part I.	23e. Did	tobacco use contrit	oute to the cause of death?
res that the signed by	d by								_ 1 _ Y	es 2 No 3	Probebly 4 X Unknown
ords, P w requires the isbeen signe should be d	ete								24a. Wa		Vere autopsy findings available rior to completion of cause of
Reco	Completed								per 1 Yes		eath? Yes 2 X No
Division of Vital Records, tal or Attending Physician: The law requirs after death. *1 Director: After this certificate has been so led in by the funeral director, page 2 should to	Be	25 Was case referred	d to medical	Hospital: 1 V				of Death (Che	ck only one)		
f Vi Physi er this	P	1 X Yes 2 27. Manner of Death	No	1 X Ir		ER/Outpatient 28b. Time of In			sing Home 5	Residence 6 how injury occurre	Other:
ion of tending Pheat. cor: After the funeral	<u>e</u>	1 Notemal	5 Pendi	(Month,	Day,Year) 7-16-12		1 V	s 2 X No	1	t took d	
ivisior lor Atteno after death Director: d in by the	fical	2 Accident 3 X Suicide	_	gation			, factory, office but	ilding, etc.	28f Location	(Street and Number	or Rural Route Number, City
Div pital cours at ours at teral D	Certification:	4 Homicide	deterr		Fd:Re	sidence			or Town, Finksh	State) 2525 Iourg, MD.	Baltimore Blvd.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Frans	Medical (/sician: To the best iner: On the basis of	examination and				d due to the caus	e(s) and manner as	stated.
□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Me	29b. Signature and till	e of certifier	and manner sta	ited.		29c. License	number		29d. Date signe	d (Month, Day, Year)
		()	when	my)			O.C.M	.E.		July 21, 2	012
	t	30. Name and address									
		Laron Locke 31. Date filed (Month)	MD. As	sistant Medical I	Examiner istrar's Signatur		more Street, E	Baltimore, I	MD 21223		
St Regist		JUL ,	2420	12 Server	Sudi S Signatur	park					
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amend #20b Per FH G929 7/34/2012 III
Department of Health and Mental Hygiene

Cortificate of Dogth

		1	For State Registrar	"State of Ma	•	-	tificate of E		IIIU IVI		Reg. No.	2012	231.16
	Disciple	/	Decedent's Name (First, Middle, Last))						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia Medic	al	Rohning P	iero						7414	17	, du/2	# : 53 P M
1	Examin	er	4a. Facility Name (if not institution, gibe s	1	- 1		4b. City, Town, or	Location of	1		4c. Co	ounty of Death	
	Funeral		5. Social Security Number 6. Sec	- DSA	(In yrs. last birtl	hday)	If Under 1 Year		4 Hrs.	8. Date of Birth	7		place (State or Foreign
	Director		A CONTRACTOR OF THE PARTY OF TH	☐ M 2 🂢 F	72	Yrs.	Months Days	Hours	Min.	(Month, Day 11/16/		Cour	NY
	nd now at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town		cation			11/10/	1/3/		10d. Inside City Limits
	larylar 3a-f sl iffied	Director	MD BALTIM	ORE	RAND	ALL	STOWN						1 ☐ Yes 2 🔀 No
	the N or 28	ᄒ	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Cou	ntry?
	h with ns 23e	Funeral	3830 CHERRYBROOK			1	21133			, , , , , , , , , , , , , , , , , , ,	USA		
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	린	11. Marital Status 1 ☐ Never Ma <i>rr</i> ied 2 🖾 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N		13. \	Was Decedent of H f Yes, specify Cuba	ispanic Ong an, Mexican	in? (Spec , Puerto F	Rican, etc.)	14	. Race - Ameri Black, White,	
99	safter ral", o Exarm	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	10	1	l∐Yes 2. MiNo	Specify:			Sp	ecify: WHI	TE
5-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra-		16a.	Deced (Give	dent's Usual Occup	ation during most	of workin	ıg	16b. Kind	of Business/Ir	ndustry
121	thin 72 me. than than be Me	E O	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ìife. D	O NOT use retired) HOMEN	MAKER				OWN H	IOME
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lan		잍	HERMAN		WAC	HS		TAN	ΙΥΑ			SUSS	MAN
Maryland 21215-0036	2 should by th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationship (Ty				ng Address (Street						
	1 and 2 if Health item 27 other tr		HOWARD S. PIERCE/ 20a. Method of Disposition	HUSBAND			O CHERRYI				_	OWN, MD	
Baltimore,	o ° ' = '=		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemete	ry, crer	zion (Name or natory or other place ZION CONC	· i)7/22) 7/2 6	72012 /12		SEDALE,	
Balti	permit. Pag Department Important: any injury c								SON &	BROS.,	INC. MD 21208		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused ne gause on each line.	the death. Do r	not ent	er the mode of dyir	ng, such as	cardiac o	r respiratory an	est,		Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	Sut Y	iev	10	cle						Onset and Death
	Medical Examiner		resulting in death)	Due to or as a	consequence	of):							
		ner	Sequentially list conditions, if any, leading to immediate	b. Due (or as a	consequence	of):	1.						
	uted od ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c. 5ma-41	bound		setze wi	c k	pu	1.4000	2	24	
	ate be executed physician and the burial-transit	ig E	resulting in death) Last	Due to (or as a	consequence	01):							
760	# E #	edical		d									
Box 68	ath certific attending I for use as	ĮĘ.	23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy	h 3[☐ Ectopic pregnan	cv			23	Bd. Date of deli	*
. Bo	hat the death ed by the atte detached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at 9 Unknown			Other (specify)					Month	Day Year
P.O.	es that the igned by be detailed		Part II. Other significant conditions co	-	ut not resulting	in the	underlying cause g	iven in Part	l.				the cause of death?
ds,	requires been sig should t	ted	Coroha's ditt	V.i						1		`	obably 4 Unknown
of Vital Records,	has be	Completed by								24a. Was auto perfo		prior to c death?	opsy findings available completion of cause of
Ä	sician: The law I certificate has b director, page 2 s	Be Co	25. Was case referred to medical				26. F	Place of Dea	th (Check	1 Yes	2 20 No	1 ∐ Yes	2 🗆 No
Vita	Physicia this certi ral direct	10 B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 🔀 Inpatie	ent 2 🗆 ER/O	utpatie	ent 3 DOA Ott	ner: 4 □ N	ursing Ho	me 5 🗆 Resi	dence 6	Other (Speci	fy)
n of	nding Phy tth. : After thi e funeral	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day		Time o	wor		- 1	28d. Describe h	now injury o	occurred	
Division	l or Atter after dea Director d in by th	Certif	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju building, etc		arm, st	reet, factory, office			28f. Location (City or Tox		Number or Rur	al Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certificate:	(Check 2 Medical Evam	sician: To the best of the part of the basis of exactitioner: To the	amination and/	or inve	stigation, in my opin	ion, death o	ccurred at	the time, date a	and place, a	and due to the o	ause(s) and manner stated.
	To the vithin To the	2	29b. Signature and title of certifier				29c. Licens					signed (Month	
			AliLe 1-	Histo	-		H	437	74	c	JU/4	19.	2012
0			30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type,	Print)	tal	RAI	deller	tra	MED	4/400
/	Sta Registi		31. Date filed (Month, Day, Year)	2. Registra	r's Signature	bar	New 1	,					/

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Thomas Edward Quinn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center TOLUSON Joseph Medical 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 213-28-2156 1 **X** M 2 □ F 81 **Director** January 20,1931 Baltimore, Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 XNo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 8637 Richmond Avenue 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 **CPA** Self Employed and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Edward Quinn Edwardine Regina Ruckle Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8637 Richmond Avenue Parkville, Maryland 21234 Nancy Quinn (Spouse) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State July 23,2012 Forest Hill, Maryland Evans Funeral Chapel-Rel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenset

22. Name and Address of Facility
Evans Funeral Chapel & Cremation
8800 Harford Road Parkville, Ma

23a. Part 1. Enterture disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Decompensated disease or condition Medical resulting in death) Du t (or as a consequence of): **Examiner** unknown if any, leading to immediate cause. Enter Underlying Examine use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last severe Hypercarbic Due to (or as a densequence of): nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the hours. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

2 4 2012

32. Registrar's

Osler Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cindy L. Ruppert 2012 Medical July 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1190 Route 97 <u>Cooksville</u> Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 214-62-1568 Country Director 1 M 2 F 59 Aug. 26, 1952 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 👽 No Howard Cooksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1190 Route 97 21723 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Ş 1 Yes If Yes, Giv 2 (No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Owner Sanitation Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Robert Yauger Betty Crossland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Ruppert (Spouse) 1190 Route 97 Cooksville, MD 21723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 7/21/2012 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Breast Physician/ (mcer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ing physician and as the burial-trans Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: 2 🗆 No 1 Tyes Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fur ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mord Million 04768 7/21/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Miller

31. Date filed (Month, Day, Year)

1525

32. Registrary Signature

21117

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 2012 23420 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 8:05 A M Thomas Michael Roberts Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6741 Eastern Avenue Takoma Park Montgomery Funeral If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 069-68-1679 1 🛛 M 2 🗆 F 1968 June 7, New York 44 or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Montgomery Takoma Park 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6741 Eastern Avenue 20912 United States iral", or items? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, yes 2 X No If Yes, Give Year or □ Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Caucasian other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than National Academy Elementary/Secondary (0-12) College (1-4 or 5+) Internet Editor of Sciences Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Roberts Emily Otwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Patricia Lynn Mallin / Wife 6741 Eastern Ave. Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/25/2012 Woodbine, Maryland Signal of Funeral Service Licenses Color Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 13 years Ph_sician/ Glioma disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Day Month Year ate has been signed by the a page 2 should be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed death? 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of ë 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 X Natural 5 \square Pending Certificat death. 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20066034

State Registrar

Matthias Holdhoff 401 N. Broadway 32. Relistrar's joeaty

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Las

Baltimore, MD 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #5 PER FH G930 8/21/2012 JF.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:95AM William Rudy 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RAVEN If Under 24 Hrs. 8. Date of Birth (Month, Day You 9. Birthplace (State or Foreign **Funeral** Months 206-26-1 Director 80 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MDBaltimore Catonsville 1 🗌 Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 314 Reserve Ct. 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates t of Health and Mental Hygiene.
If item 27 is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Materials Management General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wasil Rudy Anna Maruschak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha K. Rudy, wife Reserve Ct. Catonsville, MD. 21228 314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 260c2-ocation - City or Town, State Ju29 14. Department of H Important: If ite 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Trinity Russian Orthodox Church injury (4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD any in 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Rd 21227 Arbutus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-trar resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 ☐ No 3 ☐ Probably 🔊 Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Uursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending within 24 hours a er death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 only one) 29b. Signature and title of certific 2012 3) Name and address of person who completed cause of death (Item 23a) (Type, Print) X/ANGROWG

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:20 AM Month 2012 Physician/ attems U Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Raven Community Living enter 9. Birthplace (State or Foreign County) Waryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month 104/28/1943 Months Min. Days Hours 1 🖾M 2 🗆 F 218-36-7094 69 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 15106 Hanover Pike 21125 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Xyes 2 □ No Army Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify White 3 Widowed 4 Divorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked o any linjury or other traumatic eve once. ည Helen Brown Raymond Raffensberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 876 Main Street, Lewiston, ME 04240 Melissa Marie Knight / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 7/24/2012 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Or et and Death Immediate Cause (Final age Physician/ disease or condition resulting in death) Medical Yeavs Examiner ONAV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of physician and s the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ To the Hospital or Attending Physician: The law requires i within 24 hours after death.

Within 24 hours after death.

On the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy prior to completio death? 1 ☐ Yes 2 🗹 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 27. Man r of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 2 No М Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 0 4 1 3 6 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NA 2 Boule 30. Name and address of person who aven 21218 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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Nendell Richardson	State of Maryland / Department of Health and Me

ental Hygiene

2012 23423

		1- For State Certificate of Death Registrar		g. No.	12 2342					
Physici ledical Exami		Decedent's Name (First, Middle,Last)	2. Date of Deat Month June 30, 2		3. Time of Death 2136 hrs					
ieulcai Exaiii	IIIGI	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea						
		Sinai Hospital Baltimore		N/A	1					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		h (MM/DD/YYYY) 9. B Fore						
Director		214-78-9895 1XM 2 F 49 Yrs.	08/2	6/1962 °	Country) MD					
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
Maryland 28a-f show	ō	MD N/A Baltimore			1 X Yes 2 No					
Maryl r 28a-i	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?					
rith the	ral D	2510 Roslind Ave. 21215 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)	necify Yes or No-	U.S.A.	erican Indian, Black,					
leath w	Funer	1 Never Married 2 Married 1 Yes 2 X No		White, etc.	rican rician, piack,					
after c	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:			Black					
hours "natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of votation) during most of working life. DO NOT use retired to the control of the cont		16b. Kind of Business	s/Industry					
336 thin 72 se. than	Completed	8th Grade Laborer		Masonry	Co.					
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) 18. Mother's Name 18. Mother's Name		laiden Surname)						
2121 2121 ould be f Mental marked ic event,	o Be	Ernest Richardson Ethe: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	1 Manle	_	te Zin Code)					
MD 2 nd 2 shou uith and N m 27 is n	٦,	Patricia Scott(sister) 4007 Spruce Dr., 1								
re, rand free free free free free free free fre		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	,					
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify on-site Creamtory	14-12	Baltimor	e, MD					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21 Spring of Funeral Service Licentee 22 June 29 Hard of Brown 2140 N. Fulton	Jr. Fu	neral Ho	me PA					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arre	est, shock, or heart	Approximate Interval					
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic Drug Intoxication and Cocaine Use Between Onset ar Death Death								
_xammer		or condition resulting in death) Due to (or as a consequence of):								
	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
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760, icate be executed physician and the burial - transit	Medical	▼ UNPENDED ☐ AMENDED 23a,pt.II,27,28a-f,per me,g92	9 7-27-1							
876 tificate ng phy as the t	W/L	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delive Month	ry Day Year					
Box 687 The death certification in the attending properties of the contraction in the co	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		3						
O. B. true de by the ached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	o the cause of death?					
F. P.O.	d by	Atherosclerotic cardiovascular Disease	1 Yes	2 No 3 Pro	obably 4 🗹 Unknown					
ords, w requir s been s	lete		24a. Was a autops		utopsy findings available completion of cause of					
Recc The lav cate ha	Completed		perform 1 ✓ Yes 2							
Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medical examiner? [Hospital: 1 Inpution: 2 FB/Outpatient 3 DOA Others Nursing								
1 of Villing Physical Chineral direction	2	1 ✓ Yes 2 No 1 Impatient 2 ✓ Crossipation 3 Down 4 Normalist 27. Manner of Death 28a, Date of Injury 28b. Time of Injury 12bc. Injury at Work?		Residence 6 Other	er ⁻					
on C ending sath. or: Af	tion	1 Natural 5 Pending (Month, Day, Year) 1 Assided Pending Fd 6-30-12 Fd 8:40 pm 1 Yes 2 No	unknowi	1						
Division of Vital Records, tal or Attending Physician: The law requir its after death. *I Director: After this certificate has been sited in by the funeral director, page 2 should be the both the funeral director, page 2 should be the funeral director.	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rate) 3019 Rosa	tural Route Number, City					
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		4 Homicide determined (Specify) Found: Residence	Baltimor	e,MD.	10					
thin 24 the Fu	Medical	(Check only 1 Vertifying Physician. To the basis of my knowledge, death occurred at the line, date and place, and one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	at the time, date a	e(s) and manner as sta and place, and due to t	ntea he cause(s)					
T Wii	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)					
		O.C.M.E.		July 1, 2012						
and		 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21 	223							
	tate	31. Date filed (Month, Day, Year)								
Regis		11 2 4 2012 Viene B. Jane			l l					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20^{ay} Month JULY 2012 ROBERT RODY 02:20A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 212-24-9094 1 X M 2 □ F 85 06/22/1927 MD Usual Residence of Decede th end Mental Hygiene. 27 is marked other than "natural", or items 23a or 28e-f show traumatic event, <u>the Medical Examiner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene. and tiffers 23a or 28e-f sho start: If item 27.5 is marked other than "natural", or items 23a or 28e-f sho ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔯 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2605 OLD COURT ROAD 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ATTORNEY LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BENJAMIN RODY NETTIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMILY RODY / WIFE 2605 OLD COURT ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
eny injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 07/22/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) <u>Examiner</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the deeth certificate be executed the attending physician and the for use as the bunet-transit Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time = ** IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 L 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sate has been signated bage 2 should b 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 잍 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 D Pending n 24 hours are. The Funeral Director: After and the fundately filled in by Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Cheg edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sig ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00071287 7-20-12 ess of person who completed cause of death (Item 23a) (Type, Print) St. #4105, Balthouse, M) 11201 · Charles 67 31. Date filed (Month, Day, Year) State 2 4 2012 Registrar

DHMH 17 Rev 06-2011

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, has After this after death

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Certificate:

Medical

29b. Signature and titl

resure. Hydrocepholos 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuous Nysie Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

29c. License number

31926

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5:45

10d. Inside City Limits 1 Yes 2 X No

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

20/12

Year

white

Ам

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Nelson Carey-1447 York Road-Lutherville, Maryland 21093

31. Date filed (Month, Day, Year) 2 4 2012

24 hours hours

within 2 To the

Stein Frances

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			For State	State of N	laryland / Dep	ertment of l ertificate of l		Mental Hy	0	010 001.20	
			Registrar 1. Decedent's Name (First, Middle)	e, Last)		runcate or t	Dealli	2. Date of De	Reg. No.	3. Time of Death	
r	Physicia Media		Frances E.	Stein				Month	19 ay	2012 1:46 PM	
barrio de	Examir		4a. Facility Name (if not institution		1 (r Location of Deat	1		y of Death	
34-05 ·	Funeral		Franklin Squ 5. Social Security Number		TC. I ge (In yrs. last birthday)	ROSE (If Under 24 Hrs.	8. Date of Bir	th	9. Birthplace (State or Foreign	
	Director		213-30-7655 Usual Residence of Decedent	1 □ M 2 XX F	78 yrs.	Months Days	Hours Min.	June 02,	ny, Year) , 1934	Baltimore, Marylan	
	nyland I-f sho ied at	Director	10a. State 10b. County Maryland Balt	imore	10c. City, Town or L. Rosedale					10d. Inside City Limits 1 Yes 2 YNo	
	vith the Ma 23a or 28a st be notif		10e. Street and Number 5610 Daybreak			10f. Zip Code 21206				What Country? d States	
036	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?	Armed Forces? If Yes, specific to the second of the second		lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ce - American Indian, ack, White, etc.	
Maryland 21215-0036	thin 72 hou ne. than "natu se Medical	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed) College (1-4 or	5+) (Give	edent's Usual Occup kind of work done OO NOT use retired)	during most of wor	king		16b. Kind of Business/Industry	
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ılan	should be filed and Mental Hy, Is marked oth raumatic event	မှ	Frank Nolan					ret M. D			
lan	ge 1 and 2 should be it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relations		. 1	ing Address (Street			· ·		
e, r	○ 幸 2 t		Allen Stein (S	Son)	20b. Place of Disp	7 Litaney	Lane Bal		7		
Baltimore,	Part and		1 Nation 2 □ Cremation 4 □ Donation 5 □ Other (Specify)	Gardens of	Faith Cemel	tery July	Date 24,2012		- City or Town, State , Maryland	
Bal	permit. Departr Importa any inju		21. Signature of Juneral Service	Licensee	2	2. Name and Addre	ess of Facility Chapel	& Cremat	ion Servi	œs—Parkville 21234	
ý	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, o shock, or heart failure. Let Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	only one cause on each ling a Respiration of a Respiration of the contract of the cause of the c	d the death. Do not ente. a consequence of): Stiffal	ter the mode of dyir	ng, such as cardiac	or respiratory ar		Approximate Interval Between Onset and Death	
09/	ate be executed physician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director, page 2 should be detached for use as the brompletely filled in by the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	☐ Ectopic pregnan☐ ☐ Other (specify)	су		- 1	ate of delivery lonth Day Year	
ls, P.O.	uires that the signed by all the deta	<u>ا ۾</u>	Part II. Other significant conditi	ons contributing to death	but not resulting in the	underlying cause gi	ven in Part I.			atribute to the cause of death?	
Division of Vital Records,	The law requate has bee page 2 short	Completed						24a. Was auto perfo 1 \sum Yes		Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
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Division	al or Atter s after des il Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of In	jury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (3 City or Tov		ber or Rural Route Number,	
_	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2.	Medical	(Check 2 Medical or ly or e) 3 Centry in	g Nurse Prantitioner: To ti	examination and/or inve	stigation, in my opini	on, death occurred	at the time, date a	and place, and d	ue to the cause(s) and manner stated	
	vitl Con		29b. Signature and title of certifie	my S	ND	29c. Licens	e number		29d. Date signs	ed (Month, Day, Year)	
			30. Name and address of person				2	1.4		2,222	
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	Registr	ar	JUL 2 4 20°	12 Deserve	B. Back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23427 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tibbett 22^{Day} Evan Scarff JUITY 201²2ar 10:45 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign (Month, Day Year) 922 Maryland Director 212-62-5063 89 1**XX**M 2 □ F Nov. Yrs ild be filed within 72 hours after death with the Maryland Mental Hyglene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-fs event, the Medical Examiner must be notified Maryland Harford Forest Hill 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2401 Johnson Mill Road 21050 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces 2 1 Never Married 2 Married 1 ☐ Yes 2 ☒No If Yes, Give 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dairy Farmer Farming Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be 1 Walton Stricker Scarff Roselle Homberger f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Weeks / POA P.O. Box 762 Forest Hill, Maryland 21050 Department of Healt Important: If item 27 any injury or other to Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July $^{\square}24$ 1 Burial 2 Cremation 3 Removal from State Evanstpuneral Chabel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Bel permit. 21. Signature of Funeral Service License 22. Name and Address of Facility
Evans Funeral Chapel &
3 Newport Drive Forest Cremation Service-BelAir Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) STOMACH CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• La hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and leich fill by the funeral director, page 2 should be detached for use as the burial-transi eleip. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death 9 Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an perform Be **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 ☐ Yes 2 🔀 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and ti 29c. License numbe 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKÍE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Months Day, Year) State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 1:05 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. Sounty of Death Ellico 8. Date of Birth (Month, Day, If Under 1 Yea . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 - M 2 - F Country) 8 **Director** Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No licott 10e. Street and Number 10g. Citizen of What Country? with 1 Funeral 1043 1)5A 3100 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubar, Mexican, Puerto Rican, etc.) after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Blac 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 591 permit. Page 1 and 2 should be Department of Health and Ments 19a. Informant's Name/Relationship (Tr mportant: If item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State eemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State rownsuille MI) 4 Donation 5 Other (Specify) 7-2012 Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Addre any 23a. Part 1. Enter/tipe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Hospital: 1 🗌 Yes <u>ام</u> 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 24 hours after death.
Funeral Director: After the eted filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 1 Natural 28d. Describe how injury occurred iniury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and address of perso a State Registrar

1:05 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ arol mith 1820 Medical 4a. Facility Name (ii) not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Examiner oh Ritchie Hospice Battimore NIA Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Months Min 048.24.5042 **Director** 1 M 2 X 20 Yrs 20 1932 Usual Residence of Decedent show 10a, State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director NA MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Avenue Marmon 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Department of Health and Mental Hygiene, important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exam 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 college Baltimore City Schools Educator 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) è Herman Lee John son 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) seph Smith Baltimore MD 21207 (Husband Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₽ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garnson 4 ☐ Donation 5 ☐ Other (Specify) Forest 21. Signature of Funeral Service Licensee C. Greene Flureral Services 22. Name and Address of Facility Vauchn 8728 Liberty Road Randall stown MD 21133 23a. Part 1. Ent or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or have failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Uttole Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 William

9 Unknown Month Day Year ed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be Atrial Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Smith, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★No 24a. Was an Physician: The law autopsy perform Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) \ \OSpice Hospital: 2**V**No 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA this ot 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Hospital or Attending 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) SUITE 200 Blvd 31. Date filed (Month, Day, Year State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G931, 9/14/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 19, 2012 11:27 PM <u>Alexandra Stewart Shepherd</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Northampton Manor Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Nur 7. Age (In yrs. last birthday) **Funeral** 219-50-**6264** Hours Director 1 □ M 2 🔀 F May 29, 1944 Maryland 68 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21117 4730 Atrium Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Caucasian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file հ and Mental H ' is marked oti မ Graham P. Stewart, Corona Gaynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Graham P. Stewart, III/Brother 444 Hammerstone Dr. Westminster, MD 21157 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Page 1 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Final Journey Crematory 7/23/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Homes Cremation Service P.O. Box 784 mose MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Resporting y Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 N Yes Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifici 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No ြို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nu/se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 7-20-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou House Ave, frederick MD 21701

DHMH 17 Rev 06-2011

State

Registrar

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:45AM Mary M. Schrader 2012 Ju1y Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 112 Castletown Rd. Apt. 201 Timonium If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X (Month, Day, 171-01-1667 95 **Director** 1916 Aug. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Baltimore Timonium 1 Yes 2X No or 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21093 112 Castletown Rd. Apt. 201 USA Lount, Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene.
Important: If item 27 is marked others any injury or others. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? ģ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: If Yes, Give Specify: white 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Alexander J. Patchak Helen M. Grala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Patchak/niece 4329 Cottington Rd., Perry Hall, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place 7/24/12 Loudon Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD . Signature of Funeral Se vice Licenses 22. Name and Address of Facility Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael Flagle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final CONGESTIVE FAILURE Physician/ HEART disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ITENOSIS 2 YEARS 40RTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) MONTHS FAILURE RENAU that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 Tyes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Records, **Division of Vital** s after death. Hospital 24 hours a

Certificate: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year Registrar

OLARU

ANDREEA

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N007/110

JULY 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Stanley Vincent Stylc 20°412 4:45am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Joseph Richey House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 205-22-3764 Director 1 M 2 D F Aug. 17, 1931 80 Yrs. MD Usual Residence of Decedent flied within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Baltimore 1 ☐ Yes 2 🄀 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Funeral 3914 Tila Road 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed Specify 3℃Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Barker 12th 4:45 am Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve t of Health and Mental ၉ Konstanty Stylc Mary Stanciewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Deugwillo 3914 Tila Road Parkwood MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 7/18/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Puneral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cell Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 687时 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prostale Concer 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy thruboen bolem 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes ၉ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) NOSA 1CB 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Campbell Blod, Suite 200, canal 4924 32. Registrans Sign State Registrar

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Stanley

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month マスつ chriva 7012 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ISACTI MUZE racio monium, 5. Social Security Num If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 213-09-0387 Hours Min (Month Day Year) 1 🗚 2 🗆 F **Director** 96 Dec.11,1915 MD show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 806 Silver Avenue with t 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣No Specify: If Yes Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7th College (1-4 or 5+) Crane Operator Sparrows Point should be filed with and Mental Hygien ris marked other th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 2 Harry Schriver Dora Gladfeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry G. Schriver /son 1598 Trappe Church Road Darlington MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Oak Lawn Cemetery 7/20/12 Page 1 1 Burial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ature of Funeral Service Licer 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death VaRDIO Physician disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last eu mom A and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical DOWENT certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe (1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Division of Vital Records, Completed should peen SCHRIVER 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has autopsy performed? certificate 2 🔀 No 1 Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year, 31926

State Registrar

DHMH 17 Rev 06-2011

2300 DULANEY VALLEY ROAD

TIMONIUM

MD

21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D

RICHARD CAREY,

2 4 2012

31. Date filed (Month, Day, Year)

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		-	For State Registrar	Olato o. III		Certificate of L			Reg. No.	2012	231.31
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ر الرس	Examin	er	4a. Facility Name (if not institution	och Med	CTR	, Gles		ITNI	e	County of Death	D
	Funeral Director		5. Social Security Number 216-94-3878 Usual Residence of Decedent	6. Sex 7. Age 1 □ M 2 🖾 F	(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Coul	iplace (State or Foreign ntry) ryland
	aryland a-f show fied at	ctor	10a. State 10b. County	Arundel Co.	10c. City, Town	or Location Burnie		100/12/			10d. Inside City Limits 1 ☐ Yes 2XXNo
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, Maryland	id 2 should salth and M n 27 is mar er traumat		19a. Informant's Name/Relations Mr. Layfett S.		I	Mailing Address (Street a		ral Route Numbe			Code) 21061
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 ☐ Removal from State Specify)	cemetery	Disposition (Name of comments), crematory or other place aven Mem. P		Date 21/2012		cation - City or T n Burni	
Balt	permit. Page Department Important: i any injury o		21. Signature of Funeral Service	icensee	M01121	22. Name and Address Services P.					
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00 00 00	te be executed nysician and he burial-transit	dical Examiner	Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):	_ / 16	-pr	D F		
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	Ø		30. Name and address of person	who completed cause of do	eath (Item 23a) (T	ppe, Print) 695	Am	erica	2	1036	5
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 23435

manda Sunche		State of Maryland / Department of H			2 U I g. No.	2 2343			
Physici Medical Exami	an/	Amanda Lynn Stinchcomb		2. Date of Death Month July 18, 20	Day Year	3. Time of Death 1633 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. 0	City, Town, or Location		4c. County of Death				
Funeral		Ott / tgillou / toopillar		der 24Hrs. 8. Date of Birtl	h(MM/DD/YYYY) 9. Birtl	hplace (State or			
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5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, s	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Specify:						
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Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	ļ	4 Donation 5 Other Specify: 21. Signature of Euneral Service Licensee 22. Name	and Address of Eacil	ity		Jarnie, III			
Ba perm Depa Impe		23. Part I. Enter the disease, or complications that caused the death. Do not enter the m	rose Funer	al Home of L	ansdowne ansdowne. N	D. 21227			
Physician /Medical	3 3	failure. List only one cause on each line. Combined toxicity o	i citalopr	am, Prometha	st, shock, or heart	Approximate Interval Between Onset and Death			
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Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death Funeral Director: After this certificate has been si retly filled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fa	actory, office building,	etc. 28f. Location (S or Town, St	treet and Number or Rurate)	ral Route Number, City			
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		mes	O.C.M.E.		July 19, 2012				
- (P)		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W	Baltimore Stree	t, Baltimore, MD 21	223				
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Negle	ULTE	COL TILDIA LANGE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1²6^y, 2012^{ear} Juli 6:30 Рм Clifford Ellsworth Snyder, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 345 3rd Ave. Lansdowne Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 XXM 2 □ F Min. Jan. 19 Year) 1924 Months 218-14-7569 88 Yrs Pennsylvania **Director** Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2XXNo Maryland Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 United States 345 3rd Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married XXXMarried þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes Y No Specify. Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working permit. Page 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmatic. life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) 12th Railroad Engineer Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Estelle Marie Kuhn Clifford Harry Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ruth Snyder/Wife 345 3rd Ave.,Lansdowne,Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XX remation 3 Removal from State July 20,2012 Glen Burnie,Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) uperal Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOMEOF LANSDOWNE 2719 Hammonds Ferry, Rd., Lansdowne, Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate On et and Death Immediate Cause (Final acute my ocardial
Due to (or as a consequence +): Ph_sician/ disease or condition Medical resulting in death) **Examiner** sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami sician and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 phys the t ading p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should Fibrillation Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 🗌 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No nours after death neral Director: A lilled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

of certifier

WCOKIUMO

Date filed (Month, Day, Year)
JUL 2 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1/20 N. Rally

32. Registr

July 18, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Year Hazel Beulah Shaeffer July 21 5:45 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 219-28-3651
Usual Residence of Decedent **Director** 1 □ M 2 🔀 F 80 May 22, 1932 North Carolina show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🔀 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 2238 C Rock Spring Road 21050 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or Š 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ၉ Calvin Lester Blevins Grace Beatrice Burkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 321 Lapidum Road, Havre de Grace, MD 21078 Deborah L. Steelman / Daughter Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 🔀 Burlal 2 🗆 Cremation 3 🗀 Removal from State Air Memorial Gdn. 7-24-12 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 Physician/ disease or condition Medical resulting in death) Due to (or as a consequenc - f) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or injury that initiated events Due to (or as a consequence of). and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify)
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 21 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year, 060768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHEASAPEAULE DE, BELAIR, MD 21014 MUHAMMADHADAR

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death cedent's Name (First, Middle, Last) 3. Time of Death A 2. Date of Death Physician/ Month tewar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🔀 F (MO5/24/1956 ^{Country}irginia Director 223-88-5642 56 Usual Residence of Decedent show 10a. State 10b. County at Director 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12831 Point Salem Road 21740 USA ed other than "natural", or items event, the Medical Examiner mu be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed I 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Printer 10 Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental ! ဂ္ Walter Humphrey and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 struction of Health a trant: If item 27 is Donald W. Stewart, Jr. / Husband 12831 Point Salem Road, Hagerstown, MD 21740 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/24/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dusteil Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 mg Month Year Dav Pregnant at time of death a Unknown 9 Unknown Division of Vital Records, P.O. signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 🗌 Yes Other: 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide M 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Undedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) 198 Amaria Couries, State Registrar

State of Maryland / Department of Health and Mental Hygiene										
			Registrar 1, Decedent's Name (First, Middle, Las	<i>t</i>)	Cer	tificate of Death			g. No. 4 U 1	2 23433
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	Funeral Director		5. Social Security Number 6. Social Security Number 1.	7. Age (In yrs.	19 Yrs.	If Under 1 Year If Und Months Days Hours		B. Date of Birth (Month, Day, 1)	19 32 / R	thplace (State or Foreign untri)
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	the M or 28		10e. Street and Number	a d		10f. Zip Code		10	g. Citizen of What Co	
	h with ns 23a nust b	Funeral	814 Monkto			2111	/		USA	-
	or iten	by Fu	11. Marital Status1 ☐ Never Married2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 Xes 2 No		Was Decedent of Hispanic (f Yes, specify Cuban, Mexic	can, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
215-0036	within 72 hours after death with the Maryland gjerie et then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	ed p	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		☐ Yes 2 No Speci	ify:		Specify: LU	hite.
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Ma	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. If health and Merital Hygiene, then "Hatural", or items 23a or 28a-f show item 27 is marked other than "Hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1	DOCIS TROKEL	= 10 fe	8/4	g Address (Street and Num Mon k fow	noer or stural F	Mark	to MA	24111
Baltimore,	n 0 = =		20a. Method of Disposition	Removal from State	Place of Dispo	sition (Name of natory or other place)	Da	te 2	0c. Location - City or	Town, State
time	Pag nen ant:		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		anew Va	11ey Mem Garde		26/12-	Timoniu.	
Ba	permit. Departn Importa any inju		21. Signature of Ineral Service Licens	1 2 hota	The second	Name and Address of Fac	Chapal			CES Monkton
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3760	ficate g phys	ושו		d						
x 687	attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	etal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
. Box	t the deal by the at tached fo	ysic	1 🗌 Yes 2 🗍 No 9 🗍 Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	f death 5	Other (specify)			WORT	Day Teal
P.O.	es that the signed by be detact		Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause given in Pa	art I.	23e. Did toba	acco use contribute to	the cause of death?
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of Vital Records,	has be	mple	hyponationia					24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
- R	ician: The k certificate ha ector, page		25. Was case referred to medical			26. Place of D	Poath (Chack o	1 🗌 Yes 2	No 1 ☐ Yes	s 2 🗆 No
Vita	ysician: is certific director,	To Be	avaminar?	Hospital:	☐ ER/Outpatier	Other:			ice 6 🗆 Other (Spec	cify)
of	ng Ph fter thi		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work?		ld. Describe how	/ injury occurred	
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Division	al or A s after il Direc d in by		4 ∐ Homicide determined	building, etc. (Spec		set, factory, office		City or Town,		rai noute Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		sician: To the best of my kno iner: On the basis of examinat						
	To the within 2 To the complex	Me	only one) 3 Certifying Nurs	se Practioner: To the best of	my knowledge,	death occurred at the time, d			ause(s) and manner as	
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1.1			30. Name and address of person who		em 23a) (Type, F			1dimi de	mo	2/206
1	Stat	te.	31. Date filed (Month, Day, Year)	32. registrar's Sign	nature	TWOOR VIVE	13 00	17 - 18 / 7		
	Registra		JUL 2 4 20	12 Down	A. 100	arles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Joseph Leonard Thomas, Medical 2012 6:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Co. Towson Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Director 219-20-6694 1 ☑ M 2 □ F 84 21,1927 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show Idical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Dunda1k 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 8428 Kavanagh Road United States 12. Was Decedent Ever in U.S. Armed Forces? WWII 1 ☑ Yes 2 ☐ No WWII If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify. Completed 3 XWidowed 4 Divorced Year or Dates. Korean White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Millwright 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Amelia Darchicourt Eugene Thomas, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8510 Sandy Plains Road Dundalk, Maryland 21222 Mrs. Kathleen Haines (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 7/19/2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Duda - Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a Part 1. Enter the disease or complications that caused shock, or heart failure list only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Cardorenal sundrome Ohset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Schemic Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA WOSDIGE 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) carlina 7 2012 BX1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHALLES MIC 6701

Registrar
DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

2 4 2012

32. Registras Signa

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Thing Sarah Annette Sulc 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buenie ANNE AR Baltimore Washington Medical Center Glen Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth **Funeral** (Month, Day, Year) Director 216-35-8944 1 🗆 M 2 🗓 F 20 11/07/1991 Maryland , or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? Funeral 21061 U.S.A. 298 Scotts Glen death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of the alth and Mental Hygiene. 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene is marked other tha Student Dependent 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Love11 L. Thing, Jr. Jayne Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 298 Scotts Glen Glen Burnie, MD Mrs. Jayne D. Thing / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Meadowridge Mem. Park 07/26/2012 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licensee MO1479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify,} \) 2 No ER/Outpatient 3 DOA Inpatient 2 🗌 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending ours after death.

leral Director: Af

filled in by the fu 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 2012 person who completed cause of death (Item 23a) (Type, Print) Burne . MI Registrar

12-04904 Sallie Lou Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1- For State Registrar	Í	Ce	rtificate o	f Death		,,,	Reg. No	. 21		2 2344
Phys		ın/	1. Decedent's Name (First, Mic	dle,Last)		 · 			2. Date of I	Death Day	Year		3. Time of Death
Medical Ex	ami	ner	Sallie L. T						June 29	9, 2012			0550 hrs
*			4a. Facility Name (if not institute 2015 East-West High		number)		4b. City, Town, Silver Spr		of Death		ic. County of Montgom		
Fune	rol		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Y		r 24Hrs. 8. Date of		_	-	place (State or
Direc			unk	1 M 2 XF			Months D	ays Hours	0.00-		1929	Foreign	
	-	- 1	Usual Residence of Decedent	I W ZAF	0.3	Yrs	<u>. </u>		037	12/	1929	000	
	Any	ı	10a. State 10b. Count	ry .	10c. City,	, Town or Locat	ion					T	10d. Inside City Limits
p _o	i how	_	MD Balt	imore Co	o.	Park	ville						1 Yes 2 X No
faryla	at or	Director	10e. Street and Number				10f. Zip Code			10g. C	tizen of Wha	at Counti	ry?
the N	23a or 28a-1 sho notified at once,		3 Mercury C	t.			21	234		Ţ	J.S.A	•	
215-0036 be filed within 72 hours after death with the Maryland mat Hygiene.	De no	Funeral	11. Marital Status		ecedent Ever in U. Forces?				in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - White,		an Indian, Black,
death	or ite	Ë	1 Never Married 2	1 Yes	2 🔀 No		-6-		r derio rticari, etc.)				o.le
s after	niner,	<u>a</u>		Divorced If Yes, Give Y or Dates:				lo specify:	to distance and disease	Iaos	Specify:		
hour	Exar	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12		(1-4 or 5+)		ost of working I		kind of work done use retired)	160.	Kind of Bus	iness/inc	dustry
36 hin 72	other than "na the Medical Ex	<u>ğ</u>	12th Grade	z) Genege	(14010.)	Took	photo	s for	Visa	F	edera	1 G	overnment
od wit	be M	튅	17. Father's Name (First, Midd	le, Last)			_		s Name (First, Midd				
21215-0036 suld be filed within 7 metal Hygiene.	event, t	Be	Jenkin Huds	on				Dora	a Flemin	g			
Should and Me	tic ev	2	19a, Informant's Name/Relation				-		ber or Rural Route I		-		
	77 m		Elijah Thom	as Sr.(I	lusband) 3 Me	rcury						
	other traumatic		20a. Method of Disposition 1 Burial 2 Cremati	ion 3 Removal	from State	crematory or ot	her place)		UNK Date		Location - 0		
imore Pages 1 ment of H	or of		4 Denation 5 Other	Specify:	on	0site					altim		
Baltimore, permit. Pages 1 a Department of He	in bou		21. Signature of Funeral Service	ce dicensee	4	2 3°C	seph F	ss Brow	vn Jr. F	une	cal H	ome	PA
		9	23a Part I. Emir the disease,	or complication, that	caused the death				on Ave.,				MD 21217 Approximate Interval
Physic /Medi		1	failure List only one caus	se on each live.				g, -us as -s					Between Onset and Death
Exami	ner	4	mmediate Cause (Final diseas or condition resulting in death)		Bronchop a consequence o		.a					\rightarrow	
			Sequentially list conditions,	b									
		je l	if any, leading to immediate cause. Enter Underlying Caus		a consequence o	of):							
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cuted	- transit			d									
5 5		Medical	X UNPENDED	AMENDED	23a,pt.I	I,27,pe	r me g9	31 9-2	28-12 sm				
760, icate be ex	the burial		IF FEMALE: 23b. Was decedent pregnant in	the	s, outcome of preg	· —				2	3d. Date of d		
68. certifi	for use as t	ian	past 12 months?		birth gnant at time of de		tal death ³ her (S <i>pecify</i>)	Ectopic	pregnancy		Month	Da	y Year
Box e death c	d for u	Physician	1 Yes 2 V No 9 U	Jnknown g Unk	nown	3 0	ner (Specify)			- 1			
O at the	gc a		Part II. Other significant cond	litions contributing	to death but not re	esulting in the u	inderlying cause	given in Par	rt I. 23e. Di	d tobacco	use contrib	ute to th	e cause of death?
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requ	2 should	힐	disease: hep	atitis C i	nfection	with ci	rrhosis	of the	24a. W	as an itopsy			psy findings available mpletion of cause of
ecc he lav		Ĕ	decubitis ul						pe	rformed?		eath? ✔ Yes	2 No
ian: The	tor, p.	BeC	25. Was case referred to medic	cal		<u>a</u>	26.Pla		Check only one)				
Vita	di j	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing Home 5	Resid	ence 6	Other:	
of ing P	unera	اڃَ	27. Manner of Death	28a. Dat (Mon	te of Injury hth, Day,Year)	28b. Time of I		jury at Work?		be how in	jury occurre	d	
ion ttend	the f	gi		ending vestigation			1_	Yes 2	No				
Division of Vital Records, tal or Attending Physician: The law requires a face despised to the law requires of the law requires of the despised to the lawner of the contribution of the lawner of the	filled in by the funeral	Certification:		ould not be	ace of Injury - At he	ome, farm, stree	et, factory, office	building, etc		n (Street n, State)	and Number	or Rura	I Route Number, City
DIVIS	y fille		4 Homicide	termined (Specif)									
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.	completely	ical	(Check only	Physician: To the be kaminer:On the basis	est of my knowleds s of examination a	ge, death occur ind/or investigat	red at the time, tion, in my opini	date and plac on, death occ	ce, and due to the c curred at the time, d	ause(s) a ate and p	nd manner a lace, and du	as stated e to the (cause(s)
Tot	сош	Medical	29b. Signature and title of certi	and manner	stated.			nse number			Date signed		
			111	C		MA		.M.E.			y 3, 2012		
		}	30. Name and address of person	on who completed ca	use of death (Item	1 23a)							
			Russell Alexander M		Medical Exam	*	W. Baltimor	e Street, E	Baltimore, MD	21223			
1			31. Date filed (Month, Day, Yea		Registrar's Signatu	ball	,		Obhic				
Re	gist	rar	1111 2 4 20	17 / Lana	A. B.	Back	•						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2012 2:30 Рм Rose Mary Volkmer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Months (Month, Day, Year) Country) Director 482-26-2094 1 M 2 K F Yrs 1928 Dec 27, 83 Iowa Usual Residence of Deced er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 11608 Parkedge Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. چ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Completed Year or Dates Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 12 should be filed within 72 hith and Mental Hygiene. 27 is marked other than "nr traumatic event, the Medi (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Education 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Zelda Milliard Martin Jones permit. Page 1 and 2 should t Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Eldon Volkmer / Son 11608 Parkedge Dr. Rockville, MD 20852 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/25/2012 Woodbine, Maryland 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔯 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🛭 Other (Specify) HOSpice 2 X No 1 Yes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛭 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital c within 24 hours a: To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year)

JUL 2 4 2012 32. Registrar's Signature State JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Quinton Winder		- For State Registrar	Sta	te of Maryla		partment o e <i>rtificate o</i>		and	Mental H		Reg. No	. 20	12 2341	
Physician Medical Examine	1	1. Decedent's Name	e (First, Middle,	Last) Quint	in Tim	nothy Winder	nder		-	2. Date of De Month 6 July 46,		Year	3. Time of Death 0215 hrs	
)		4a. Facility Name (i		give street and nu					cation of Death			lc. County of Dea		
Funeral Director		5. Social Security N 2 1 7 – 0 4 – 8	8486 I	. Sex		s. last birthday) 35		Year Days	If Under 24Hrs Hours Min		,	976 Fore C		
Aaryland 28a-f show any 1 at once,	ľ	Usual Residence of 10a. State MD	Decedent 10b. County			ty, Town or Local Baltimo							10d. Inside City Limits 1 X Yes 2 No	
the Maryland ba or 28s-f sho otilied at once.		10e. Street and Nur 5 0 6		Avenue)		10f. Zip Coo	212	12		10g. Ci	tizen of What Cou USA	untry?	
and 2 should be filed within 72 hours after death with the Maryland leath and Memal Hygiene. tem 27 is marked other than "natural", ur items 23a or 28a-f shoot rammatic event, the Medical Examiner must be notified at once. TO Be Commission by Elineral Director	⋧┞	11. Marital Status 1 X Never Marrie 3 Widowed 15. Decedent's Ed	4 Divor	ried Armed Fo	Give Year 1 Yes 2 X No specify: es: nest grade completed) 16a. Decedent's Usual Occupation (Give			flexican, Puerto specify: n (Give kind of v	n, Puerto Ricán, etc.) γ: Sρ		White, etc.	rican Indian, Black, ack /Industry		
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exau	- Inhiere	Elementary/Seco	ondary (0-12)	College (1		during m	ost of working dscap:	ing	g Agricu			elf empi gricult	loyed ure	
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Baltimore, permit. Pages I as Department of He. Impurant: If ite	L		Other Spec		om State	Ardent	Crem	ress of	-	24-201		anover		
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Physician Wedi Examiner			ly one cause or Final disease		nshot Woı	unds							Between Onset and Death	
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lox 6876 leath certificate a attending phy for use as the		F FEMALE: 3b. Was decedent past 12 months 1 Yes 2 N	?	23c. If yes, of 1 Live b	outcome of pre irth ant at time of	egnancy 2 Fe	12 SIII tal death her (Specify)		Ectopic pregna	ancy	23	8d. Date of deliver Month	y Day Year	
i, P.O. E lires that the d signed by the lbe detached d by Physical by Physical land land land land land land land la	3	Part II. Other signif	icant condition	ns contributing to	death but no	t resulting in the u	inderlying cau	se give	n in Part I.		-	natura, patronos	the cause of death? bably 4 Unknown	
of Vital Records, ng Physician: The law requires ther this certificate has been signeral director, page 2 should be n: To Be Completed		25. Was case referr	ed to medical				26 P.	ace of	Death (Check o	1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of	
F Vital Physician or this cert ral directo To Be	1	examiner?	2 No	Hospital: 1 II	npatient 2	✓ ER/Outpatient		_			Reside	ence 6 Othe	r.	
ision of Attending Pher death. cctor: After tilby the funeral		27. Manner of Death 1 Natural 2 Accident	5 Pending		of Injury Day Year) 012	28b. Time of li 0128 hrs			t Work? 2 ✔ No	28d. Describe Subject sh		jury occurred		
Division o vapital or Attending hours after death. meral Director: Aft y filled in by the fune Certification:		3 Suicide 4 Homicide	6 Could n	28e. Place	of Injury - At Row Hou	home, farm, stree	et, factory, offic	e build		or Town,	State)	and Number or Ru , Baltimore, MD	ural Route Number, City	
Di To the Hospital within 24 hours a To the Funeral I completely filled		one) 2 🗸	Medical Exami	sician: To the best ner:On the basis o and manner st	f examination	_	ion, in my opir	nion, de	eath occurred a		e and pla	ace, and due to th	ne cause(s)	
		29b. Signature and	4			MO	29c. Lic O.	ense n C.M.I			29d. Date signed (Month, Day, Year) July 17, 2012			
		M. Name and address Russell Alex	ander MD.	Assistant M	edical Exa	miner 900		re St	reet, Baltim	ore, MD 2	1223			
State Registra	е ³	31. Date filed (Mark)	^{h,} 2 ^y 4e201	2 232. Re	gistrar's Sig	sture parks	1					DOME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ н. Month Year Georgia Windes 10:50 P M Medical Jul v 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7423 North Point Road Edgemere Baltimore Co. Apt. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year) Director 220-18-9632 1 □ M 2 🏋 F Yrs 84 Aug. 7,1927 Mary land Usual Residence of Decedent or 28a-f show be notified at 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 Yes 2 X No MD Baltimore Edgemere 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hyglene.

The 23 is marked other than "natural", or items 23a on other traumatic event, the Medical Examiner must be, other traumatic event, the Medical Examiner must be. Funeral 7423 North Point Road 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 x Widowed 4 □ Divorced Specify. Completed White Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Wise Helen Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William Dickey, Jr. (Son) 3009 Salisbury Ave. Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important; If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Entombment Holly Hill Mem. Gdns. 7/25/2012 Middle River, MD 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7022 Wise Ave. Dundalk, Md 21222 21. Signatur Funeral Service Licensee Cre r Reed omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, my one cause on each line. 23a. Part 1. Enter the pisease, or shock, or heart failure. List Approximate Interval Between Immediate Cause (Final BLADDER Physician/ ANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) attending physician attended for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death the ed by t detach been signed k should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy 1 ☐ Yes 2 🔄 1 Yes 2 No 25. Was case referred to edical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending s after death.

I Director: A din by the fu 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1) (12102 24 12 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) AF 20 2

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2^{Ppy}, 2072 4:50 P M Louis Leonard Wood, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rockville Montgomery 11760 Gainsborough Road 7. Age (In vrs. last birthdav. If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Day, Year) Davs Hours **Director** 579-46-3876 1 🛛 M 2 🗆 F July 26, 1931 Washington DC 80 Usual Residence of Deced 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 I No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11760 Gainsborough Road 20854 United States death or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🎛 No If Yes, Give þ 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 nours and ment of Health and Mental Hygiene.
Itant: If item 27 is marked other than "natural", jury or other traumatic event, the Medical Exal 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry المالية المال (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical 5+ Organic Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname မ Warland Butler Louis Leonard Wood, Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, MD 20854 Wood / Wife 11760 Gainsborough Rd. Carol 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Journey Crematory 7/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pancreatic Cancer years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 autopsy page 2 perforn death? certificate Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 🗌 Yes 2 🗌 No hours after death I Director: A ed in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

X DHMH 17 Rev 06-2011

within 24 hours a

To the Funeral C

completely filled

Medical

29a. Certifier (Check

Victor

Priego

30. Name and address of persol who completed cause of death (Item 23a) (Type, Print)

Rockledge

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D23308

4100 Bethesda, MD 20817

July 23, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e Per FH G929 7/27/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jul 4 Daniel Winn 04:52 M Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death of Maryland Medical Baltimore Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral Director** 51 December 15, 1960 Michigan 1**X** X M 2 □ F or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Nottingham 1 Yes 2 No 10e. Street a**Bedrock** 4316 Bedford Circle Apt 301 ò 10f. Zip Code 10g. Citizen of What Country? 21236 Funeral United States "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XX No Specify: White Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5 ± Trouble Shooter Medical Equipment Be 17. Father's Name (First, Middle, Last)
William Winn 18. Mother's Name *(First, Middle, Maiden Surname)* Pauline Lois Sherwood Ith and Mental F 27 is marked of traumatic ever မ 19a. Informant's Name/Relationship (Type, Print)
Pauline L. Winn/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 352 Thalia Ave., Rochester Hills, Michigan 48307 or other tra 20a. Method of Disposition
1
Burial 2
Cremation 3
Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Department of Important: If any injury or once, AtlanticCrematory July 23,2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc 21. Signature of Funeral Service Licenses M au 3631 FallsRoad, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cryptosporidium, Giardia Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown rthis certificate has been signal director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 🗌 Yes 2 🗆 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors and the funeral directors. 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural (Month, Day, Year) injury 5 Pending 2 Accident 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one NPI 1285900803 Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Fayette St Apt 1003 Adnan Baltimore, MD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O^{Mgnth} 2¹3⁸ 201⁸2¹ 8:00A M Verl R. Wagner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 320 Bell Road Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 D F Months Yrs 0270371915 214-01-1754 97 Director Usual Residence of Decedent or 28a-f shov 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits the Maryland by Funeral Director 1 Yes 2 No Carroll MD Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with 320 Bell Road 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. 0. 1 Never Married 2 Married 1 Yes 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Columbus H. Wagner Ruth P. Bair 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Nancy Houck-daughter 3524 Lawndale Rd., Reisterstown, Md., 21136 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch 7/27/2012 Westminster 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E. Main St. Westminster, Md., 21157 rvice Licensee 254 E. disease, or complications that caused the death. Do not enter the mode of dying. Approximate Interval Between Onset and Death Part : Immediate Cause (Final disease or condition Providican Medical resulting in death) Due to (or as a consequel **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No After this certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar

only one) 29b. Signature and title

31. Date filed (Month, Day, Year) Registrar's Signature

m 23a) (Type, Prin

Certifying Nurse Practions, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2^{Day} 2012 Thelma Reynolds Weishaar 5:04A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 N 10/21/1920 Country) 213-18-9059 91 Director MD Usual Residence of Decedent 23a or 28a-f show ust be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Westminster 10g. Citizen of What Country? Funeral 2732 Littlestown Pike 21158 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:Whi<u>te</u> If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Albert Reynolds Mabel Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shiryley Cullison-daughter 2732 Littlestown Pike, Westminster, Md 21158 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/25/12 Evergreen Mem Finksburg gnatur Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 St. Westminster, Md., 21157 Main Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementia Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No isigned by the a ld be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be Completed 1 Yes 2 No 3 Probably 4 Inknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No After this certificate has page death? 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 🖪 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Aursing Home 5 Residence 6 Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2/1 52035 2012 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21152 Warmerta 5000

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joyce May Welsh JULY 1250 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A ST AGNES HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year I If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 212-42-5791 1 - M 2 T 69 Hours **Director** March 5, 1943 Maryland ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Elkridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6029 Claire Drive 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) should be filed hand Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname) William W. Lanahan Elberta Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Arthur C. Welsh, husband 6029 Claire Dr. Elkridge, MD. 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State injury or cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Memorial Park 07-21-2012 4 Donation 5 Other (Specify) Elkridge, MD 21. Signature of Func al Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, sician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury ecomyosarcom the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of physician Be Completed by Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? 2 200 Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending Accident within 24 hours after death To the Funeral Director: Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowle 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar V-600687 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rhonda Kay Watters Tal ам Medical . Tacility Name (if not institution **Examiner** give street and number County of Death Social Security Number (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 □ F 543-92-5242 Min. (Month/23/1966 45 Months Couctalifornia **Director** 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Charles 1 X Yes 2 □ No Hughesville 10e. Street and Number ò 10f. Zip Code "natural", or items 23a or edical Examiner must be r 10g. Citizen of What Country? Funeral PO Box 613 20637 USA 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. by 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced White Year or Dates r than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Administrator Federal Government 27 is marked other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Larry D. Watters Shirley Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Larry Watters / Father 412 E. Maple Street, Sequim, WA 98382 ō Baltimore, 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crematory 7/24/2012 4 Donation 5 Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, POP Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final 2 Onset and Death Physician. disease or condition resulting in death) Medical o (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and burial-trai Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 2 🗌 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe After this certificate 2 🗆 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Example 1 Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number . Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year PATRICIA ANN WYNNE July 8:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5 Wilfred Court Towson Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav. 9. Birthplace (State or Foreign **Funeral** Months 214-36-7864 Director 72 1 □ M 2 🗓 F Mar 17, 1940 Maryland or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County 1 ☐ Yes 2 🗶 No Baltimore 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be n 10g. Citizen of What Country? with Funeral 21212 114 Murdock Road USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed White Year or Dates er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 ed other than event, the M College (1-4 or 5+) Bookkeeper Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. Page 1 and 2 should be rement of Health and Menta Francis Xavier Wynne Miller Miller Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Doyle (Sister) 5 Wilfred Court, Towson, Maryland 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State New Cathedral Cem 7/25/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signa Me of Superal Service Con Martin D. Lawson MTTCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER BREAST METASTATIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No or Attending Physician: 25. Was case referred to medical SISTER'S Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one

Registrar DHMH 17 Rev 06-2011

State

29b. Signature a

31. Date filed (Mon , Day, Year)

Timothy Herlihy, MD, 120 Sister Pierre Dr., Suite 204, Towson, MD 21204

D0032639

17. P.

person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician ^{Day} 2012 21, Charles L. Abbott 3:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Collingswood Nursing & Rehab Rockville Montgomery 9. Birthplace (State or Foreign Country)
Boston, MA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 019-30-7522 79 Director Dec 31, 1932 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director MD 1√Yes 2□No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 299 Hurley Avenue 20850 USA 23a Funeral items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examinations. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify 2 Specify: White 3 H Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard D. Abbott Elinor Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Abbott Jr. (Son) 2249 McKendree Road West Friendship, MD 21794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State TD Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hills Cemetery 7-27-12 Boston, MA 21. Signature Funeral Service Licenses 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310 Part / Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line / Approximate Interval Between Onset and Death 23a, Part 1 Imm late ause (Final disease or ondition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Box 68760, physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4- Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

SAYYAD YED 31. Date filed (Month, Day, Year)
JUL 2 5 2012 32. Registrar's Signature parke

30. Name and address of person who

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Rockville, MD 20850

poleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 **Eleanor** Apicella $\mathbf{J}_{\mathbf{u}}^{\mathrm{Manth}}$ $3:45 p_{M}$ 22. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeths N/A Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 🗆 M 2 🕱 F Months Days Year)1920 Hours 217-22-1960 92 March, Ti Rhode Island **Director** Yrs Usual Residence of Decedent 28a-f shov Hygiene. other than "natural", or items 23a or 28a-f shor rent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Ellicott City Howard 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3010 Chestnut Hill Dr. 21043 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð Yes 2 K No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo Specify. Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10College (1-4 or 5+) should be filed with and Mental Hygien I is marked other the Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elvira Joachil Lancelotta Lombardi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 Chestnut Hill Dr., Ellicott City, MD 21043 Vera J. Melvin (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5x□ Other (Specify) Entombment Loudon Park Cemetery 7/25/12 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Doratea Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease of inthat initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 completed filled in by the funeral director, hours after death. Ineral Director: After this within 24 hours a

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Medical	29a. Certifier (Check conly one) 1	on, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stated
_	29b. Signature and title of certifier Clinica Republic	29c. License number	29d. Date signed (Month, Day, Year)
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	teight to #300 Ba	160, MO 2/229
е	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MORNINGSIDE HOUSE BALTIMORE COUNTY BALTIMORE . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 87 Months Hours (Month, Day, Year) Director 220-12-7494 1 🗆 M 2 🖺 F Nov. 4,1924 MD. Yrs Usual Residence of Decedent Jid be filed within 72 nouse accessions 1 Mental Hygiene. I Mental Hygiene. marked other then "neturel", or items 23e or 28e-f show marke event, the Medical Evaminar must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Baltimore County 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4134 Cliffvale Rd. 21236 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 Yes 2XXNo If Yes, Give 1 Yes 2XX No Specify: **¾**M Widowed 4 □ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sewing Machine Elementary/Secondary (0-12) College (1-4 or 5+) Parts 7 vrs N/A <u>Factory Worker</u> Be 17. Father's Name (First, Middle, Last) 1 and 2 should be file of Health end Mentai I fitem 27 ie marked o 18. Mother's Name (First, Middle, Maiden Surname) Joseph Brockmeyer Agnes Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Appel (Son) 2819 Berwick Avenue Baltimore, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Depertment of H
Importent: If ite
eny injury or ot 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Parkwood CEmetery 4 ☐ Donation 5 ☐ Other (Specify) 7-27-2012 Baltimore, Md. 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 . Si ma ure of Funeral Service Licenses or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate course Filter Underlying Examine Due to (or as a consequence of): the attending physicien and hed for use as the buriel-trensit or Attending Physicien: The lew requires thet the death certificate be executed Cause (Disease or injury that initiated event resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 4 Pregnant at time of death g Unknown Month Dav Year P.O. been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe certificate 2 🗌 No Yes 2 No 1 Nes Division of Vital filled in by the funeral director. 25. Was case referred to ledical Be 26. Place of Death (Check only one) examiner? 1 Yes မ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Mannar of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospitei or Attending within 24 hours after death. To the Funerei Director: Afte completely filled in by the fun 5 Pending Natural injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number ame and address of person who completed cause of death (Item 23a) (Type.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ HRRINL \mathcal{G} 0924 ADDIE + Medical 12 Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CENTER FDIC Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 Hours (Month, Day, Feb. 22 79 , Year) 1933 $\overset{{
m Country}}{{
m N}}\overset{{
m Country}}{{
m C}}$ Director 217-34-7476 Yrs Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1508 Harford Ave. 21202 USA items 2 be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ₩Widowed 4 □ Divorced "natural", Black Completed Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nurses' Aide Bayview Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Douglas G. Palmer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Addie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton P. Arrington (son) 3536 Northway Drive, Balto, Md. 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other pages) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Loudon Park July 28,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of uneral Service Scense Calvin B. Scruggs Funeral Home \mathbf{E} Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians disease or condition MTRA-ABDOMINA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeeth). Examine Due to (or as a consequence of) -transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Day Year the detached signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been signal Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has autonsy death? this certificate 1 X Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 읆 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify nin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) VAL 30 2012 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

GIVAD

31. Date filed (Month, Day, Year,

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BALTIMORE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2012 23458													
			Registrar 1. Decedent's Name (First, Middle)	e, Last)		Cer	tiricate	OT D	eatn		2. Date of De	Reg. No.	201	3. Time of Death
	Physicia Medi		Helen Braeckl								July 2		012 Year	
0	Examii	ner	4a. Facility Name (if not institution				4b. City, To						County of Dea	
	Funeral		Catonsville C 5. Social Security Number	6. Sex 7. A	ge (In yrs. Ia	ast birthday)	If Under 1	Year	svil		8. Date of Bir		Baltim 9. Bi	ore rthplace (State or Foreign
	Director	ı	215-07-5990	1 □ M 2 X F	95	Yrs.	Months	Days	Hours		4/27/1		Ma	iryland
	and show i at	ò	Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc								10d. Inside City Limits
	Maryl 28a-f otifie	Director		imore	Ca	tonsvi	lle							1 🗆 Yes 2 🔀 No
	n with the Is 23a or nust be n	Funeral D	10e. Street and Number 16 Fusting Av	enue			10f. Zip C	ode 1228	3			10g. Citi	zen of What C	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 🎇 Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorceo	(CV O'		If	/as Deceder Yes, specify	/ Cuban	, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit Specify:	
15-0	2 hour "natu edical	plet		nt's Education est grade completed)		16a. Deced	ent's Usual (Occupat	tion	of working	7	16b. Kir	nd of Business	Industry
12121	d within 7 lygiene. ther than nt, the M	Be Completed	Elementary/Seconday (0-12)	College (1-4 or	5+)	Homem	ind of work NOT use re aker	etired)		-		Own	Home	
Baltimore, Maryland 21215-0036	ild be file Mental H narked ot natic ever	To B	17. Father's Name (First, Middle, I Antone Breckle	,							First, Middle, ide unk		,	
, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relations Arthie Shaw /										Town, State, Zi re, MD	
ore	ge 1 ar nt of Ho : If iter or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 Removal from State	20b. Pl	lace of Dispos emetery, crem	ition (Name atory or othe	of er place)		Da	ite	20c. Loc	cation - City or	Town, State
Itim	artmer ortant injury		4 ☐ Donation 5 ☐ Other (5		Tri	nity C			7	7/24/	2012	Dun	dalk, N	Maryland
ã	permi Depar Impo any ir			J. S.									al Home	land 21229
	Physician/		Immediate Cause (Final	complications that cause only one cause on each lin	d the death e.									Approximate Interval Between
	Medical Examiner		disease or condition resulting in death)	aDue to (or as	a conseque		1710	n_						Onset and Death
	Examiner	er	Sequentially list conditions,	b. —————			e	Der	nen	tia				many years
	ted J Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a conseque	elice of,.								
	execu an and rial-tra	I Exa	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
9	ate be physici the bu	dical		d										
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the decth certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spec	gnancy ify)				20	3d. Date of de Month	livery Day Year
<u>О</u>	that th ned by e detac	oy Ph	Part II. Other significant condition	ns contributing to death b	_			A			23e. Did to	bacco us	e contribute to	the cause of death?
ds,	equires sen sig ould b	ted	Depression) ATTICL	4,0	ham	Car.	XXOI	M no	Cel !	1 □ Y	/es 2 🕽	(No 3□P	robabły 4 🗌 Unknown
Division of Vital Records,	Physician: The law re this certificate has be al director, page 2 sh	Somple	pain.							_	24a. Was a autopoperfor	sy med?	prior to death?	topsy findings available completion of cause of
ita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			- :		e of Death	(Check o		2 5 NO	1 1 100	2 L NO
o t <	g Phys er this eral dii	e: To	1 ☐ Yes 2 🕅 No 27. Manner of Death	1 Inpati	ry 2	R/Outpatient 28b. Time of		Other: Injury a			e 5 Reside		Other (Spec	ify)
ono	ending sath. or: Afte he fun	ficat	1 Natural 5 Pendin 2 Accident Investig	ation	/, Year)	injury	М	work?	s 2 🗆 N	- 1	u. Describe ne	ow injury (occurred	
Divis	tal or Att	l Certificate:	3 ☐ Suicide 6 ☐ Could at 4 ☐ Homicide determine			ne, farm, stree	t, factory, of	ffice		28	f. Location (St City or Town		Number or Rui	ral Route Number,
	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2) Medical E	Physician: To the best of xaminer: On the basis of ex Nurse Practioner: To the	xamination a	and/or investig	ation, in my	opinion.	death occu	irred at the	e time date an	d nlace a	and due to the	supple) and manner stated
	ob con con		29b. Signature and title of certifier				29c. Li	cense ni	umber		2	29d. Date	signed (Month	Day Year)
/			► Aletha Vay 30. Name and address of person v GEETHA RA	who completed cause of de JAMD, 4.	eath (Item 2	23a) (Type, Pri	is Fe	214	Rd	, Be	eltima	we,	MD &	91227
	Stat Registra	е	31. Date filed (Month, Day, Year)	Densura J.	ır's Sign tuı	re A.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Desales Bor charding Physician/ Month Day Year Frances 4:501 2017 Medical July 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Atrium Village Owings Mills Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 89 219-16-8860 Director 1 M 2 KF Maryland July 1,1923 Usual Residence of Decedent or than "natural", or items 23a or 28e-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Directo MD Baltimore Owings Mills 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 Atrium Ct. Room 641 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AT&T Telephone Instalation Division Be 18. Mother's Name (First, Middle, Maiden Sumame)
Mary McNicholas 17. Father's Name (First, Middle, Last) age 1 and 2 should be filer ent of Health and Mental H nt: If item 27 Is marked ot ry or other traumatic ever မ Frank Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045 Kimberly Hodgkinson/cousin 8567 Window Latch Way Columbia, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entonoment Department Importent: If eny Injury or once. 07/21/2012 Baltimore, Maryland Loudon Park Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Allethe Bram-Smors 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Distase Amerosclerotic Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consuluence of sician and burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events ŵ Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 ‡ 98 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year 1 Yes 2 4 9 Unknown detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š ate has been signe page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate I funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other Specific Living Willy မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fu death. 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Projection: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, due the occurred at the time, date and due to the cause(t) and manner as stated MSny pahrens 29c. License number \$10057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSRAJAPAKTE MO 6934 Aviation BIVD 31. Date filed (Month Pax Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year JOSEPH 1001 AM BEAT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DISNEY ESTATES Anne Arunde SEVERN 8. Date of Birth Sept. 7.1942 If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Indiana 312-40-1444 1 🛛 M 2 🗆 F 69 Sept. Director show 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 28a-f Maryland Anne Arundel Severn 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 1868 Disney Estates Circle 21144 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 XYes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: White 3 🗌 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Air Force Aviation Pilot Hygiel other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Joseph L. Beaty Verna Lucille (Johnson) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Page 1 and 2 sh tment of Health a tant: If item 27 is 1868 Disney Estates Circle, Severn, Maryland Rita J. Beaty: Wife or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombrent Elwood Mausoleum 7-28-12 Elwood, Indiana 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death METASTATIC Physician/ Years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Duri to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suit 610, Glen Burnie, MD 21061 1600 CRAIN HWY SUKHPAL JASSI

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2 5 2012

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Scott Bennett Month 8:00 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 263-11-2934 **Director** 1 🌠 M 2 🗆 F 63 05/20/1949 North Dakota Usual Residence of Decedent or 28a-f show the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Myersville Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21773 U.S.A. 4205 Middlepoint Road should be filed within 72 hours after death and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Self-Employed Jewelrv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Bennett Helen Turnham permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Founders Way Damascus, Maryland 20872 Laurel Smith 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cremation Centerplace) 07/20/2012 4 Donation 5 Other (Specify) Hanover, Maryland Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, F.A. 21. Signature of Funeral Service Licensee 6009 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Adult Medical resulting in death) **Examiner** 2 weeks Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Incision attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X** No 1 🗌 Yes Other: ည 1🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor **To the Fune** completely fi 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title or codifi 29d. Date signed (Month, Day, Year) D0038764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 P. 2.66 . F 11110 medical 127 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 For State	te of Maryland	•			and M		_	010	00166		
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death Reg. No. 20 2 23 4									
ı	Physicia		WILFRED	R.	ВООН	Z F R			2. Date of De Month	Month Day Year				
ande.	Medic Examir		4a. Facility Name (if not institution, give street ar			4b. City, Town,	or Location of	of Death	JULY		17 2012 3:15P M 4c. County of Death			
- 1			ARCOLA HEAI	TH & REHAB	•		VER SP				TGOME:			
	Funeral		5. Social Security Number 6. Sex 220–29–0712	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birth Cour	nplace (State or Foreign		
н.,	Director		Usual Residence of Decedent	^{□ F} 87	Yrs.				JAN.28	3, 1925	GUY			
	/and f shov d at	tor	10a. State 10b. County	10c. City,	Town or Lo	cation						10d. Inside City Limits		
	Many 28a-	Director	MD MONTGOMERY	SILV	VER SE	_						1 Yes 2 □ No		
	/ith the 23a or st be		10e. Street and Number 8701 ARLISS ST #203			10f. Zip Code 20901				10g. Citizen of	What Cou	ntry?		
	eath w	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S.	13. \	Vas Decedent of I	Hispanic Orig	gin? (Speci	ify Yes or No-	USA 14. Ra	ace - Americ	can Indian		
36	ifter d ", or i		1 ☐ Never Married 2 ♣ Married 1 ☐	ed Forces? Yes 2 X No es, Give		f Yes, specify Cub Yes 2 X N			ican, etc.)	Bla	ack, White,	etc.		
21215-0036	atural	Completed by		r or Dates.		lent's Usual Occu					y: BLA(
215	n 72 h san "n Medi	Jdw	(Specify only highest grade comp	ege (1-4 or 5+)	(Give I	kind of work done O NOT use retired	during most	t of working	7	16b. Kind of I				
21	ygiene ygiene her th	Be Co	12TH		CUS	TOM OFF	CER			GO7	/ERNMI	ENT		
Maryland	oe filed intal H ced ot c ever	To B	17. Father's Name (First, Middle, Last) UNKNOWN				1			Maiden Surnan	ле)			
aryl	nould but Me Me mark		19a. Informant's Name/Relationship (Type, Print)	19h Mailir	g Address (Street	•		BARRE		State Zin	Codel		
ž	d ટ કો alth a alth a 27 is er trau		MILLICENT BOOKER/WIF			ARLISS S								
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remova	20b. Pla		sition (Name of natory or other pla	ace)	Da	ite	20c. Location	- City or To	own, State		
tim	it. Pag rtmen rtant: njury o		4 Donation 5 Other (Specify)	GAT		HEAVEN C		07/24	/2012	SILVER	SPRIN	NG, MARYLAND		
Ba	Depar Impo any ir		21. Signature of Funeral Service Licensee	_		Name and Address Address Name And Address Name						L HOME, INC. D 20785		
			23a. Part 1 Unter the disease, or complications shock, or heart failure. List only one cause	that caused the death.	Do not ente	r the mode of dyi	ng, such as	cardiac or	respiratory arr	rest,		Approximate		
4	hysician		Immediate Cause (Final Cause or condition	HRONIC OBST	RUCTI	VE PULMO	NARY I	DISEA	SE		1	Interval Between Onset and Death		
	Medical Examiner		resulting in death)	ue to (or as a conseque	nce of):									
	1	ner		ue to (or as a consequei	nce of):						_			
	uted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						als:					
	ate be executed physician and the burial-transi	al E)		ue to (or as a consequer	nce of):									
760	cate b physii s the b	edical	d								_			
687	death certificate be executed ne attending physician and ed for use as the burial-transi	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	s, outcome of pregnanc Live Birth 2 Fetal o	У					23d. Da	ate of delive	erv		
Box	death	sicia	1 Yes 2 No 4	Pregnant at time of dea		Ectopic pregnan Other (specify)	icy			1	onth	Day Year		
		Phy	9 Unknown Part II. Other significant conditions contributing		ing in the w	nderlying cause g	iven in Part I		020 Did to		A-11	ha annua af da ath O		
S,	requires that the des been signed by the s should be detached :	d by	ANEMIA	g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	identy ing educe g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1			he cause of death? bably 4 🔲 Unknown		
ord	v requ	olete							24a. Was a			psy findings available		
Rec	nysician: The law is certificate has t i director, page 2 s	omi							autop perfor 1 \(\sum \) Yes	rmed?	prior to coldeath?	impletion of cause of		
Ea .	cian; ertifica ector, I	Bec	25. Was case referred to medical examiner?				lace of Deat	h (Check o		2 43 140	1 🗆 163	2 14 140		
5	Physi this c ral din	은	1 ☐ Yes 2 🗓 No Hospital:	1 Inpatient 2 En	R/Outpatien		44 Nu			ence 6 🗆 Oth		2		
0 U	tending Fleath.	Certificate:		(Month, Day, Year)	injury	28c. Injur worl M 1	ry at k? Yes 2	- 1	d. Describe h	ow injury occur	red			
Division of Vital Records,	l or Attendii after death. Director: Al I in by the fu	ertifi	3 Suicide 6 Could not be	Place of Injury - At homo building, etc. (Specify)	e, farm, stre	et, factory, office		28			er or Rural	Route Number,		
	Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director. After this certificate has been signed by it stely filled in by the funeral director, page 2 should be detach							1	City or Tow					
:		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the only one) 3 Certifying Nurse Practit	ne basis of examination a	nd/or investi	gation, in my opini	ion, death ocu	curred at th	e time, date a	nd place and du	ie to the call	use/s) and manner stated		
	To the within To the comple	_	29b. Signature and title of certifier	/	VA	29c. Licens	e number			29d. Date signe				
						D006	4624			JULY 19	, 201	. 2		
	3 v		30. Name and address of person who completed SANDEEP SHARMA M.D				VILLE	,MARY	LAND	20852				
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 2 5 2012	2. Registrar's Signature	par	les .								
			44		7.//									

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D0026064

07-18-2012

10583 THEODORE GREEN BLV) WHITE PLAINS, MD-20695 8

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Megan Michelle Batzel State of Maryland / Department of Health and Mental Hygiene 2012 23464 1. For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 16, 2012 1849 hrs Medical Examiner Michelle Batzel Megan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Service Road off Country Club Road Allegany Cumberland | If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Months Days Hours Min. 08/15/1988 Foreign West country) Virginia 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 233-37-5387 Director 23 1 M 2 X F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 23a or 28a-f show Mineral Ridgeley or 28a-f shuw with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 USA Route 1 Box 557D Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 2 X No Yes Pages I and 2 should be filed within 72 hours after de tent of Health and Mental Hygien.

ant: If item 27 is marked other than "natural", or ir ather traumatic event, the Medical Examiner mu White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify ፩ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Nurse Baltimore, MD 21215-0036 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Batzel Watson Galen Sharon Luana Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 557D, Ridgeley, WV Galen R. Batzel / Father 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Cumberland Crematory 07/18/2012 Cumberland, MD Department o Donation 5 Other Specify 22. Name and Address of Facility Adams Family Funeral Home, ignature of Fune al Service Licenses 404 Decatur Street, Cumberland, MD 21502 Part I. Enter the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a Narcotic (morphine) and Cocaine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g929 7-27-12 sm the attending physician ed for use as the burial -X UNPENDED Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has b death? performed' certificate ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other; Scene this 1 V Yes No 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b, Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after uca...

To the Funeral Director: A Natural 1 Yes 2 X No unknown Pending fd 7-16-12 fd 6:13 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Service road off Country Club Rd. Cumberland, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be service road determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. July 17, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD 900 W, Baltimore Street, Baltimore, MD 21223 5 State Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Day Josephine July 1:00 P Butterworth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Frederick Frederick Frederick Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 416-28-2787 Director 1 🗆 M 2 😿 F 89 November 15,1922 Alabama 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ems 23a or 28a-f sh r must be notified a 1 Tyes 2 No Maryland 1 4 1 Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7401 Willow Road 21702 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. , 0 þ 1 Never Married 2 K Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Exal 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Simeon Kilgore Florence Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Hayes (Daughter) 5435 Harris Farm Lane Clarksville, Maryland 21029 20a, Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth once, 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 7-24-2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 M012 MAG 23a. Part 1. Enter the diseast, or complications that cause shock, or heart failure. Let only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 12 12 4 1 Physician/ 2 h2 m disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death be detached for Month Year Day g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 🗌 No 2-Yes Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 - Residence 6 - Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar crra

300 West 9th Street

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Austin Pearre, MD

009699

Frederick, Maryland 21702

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Charles Chester Barron JULY 0125 Medical Aa. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES BALTIMORE HOSPITAL . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 527-36-2225 1 X M 2 🗆 F Yrs 81 June 29,1931 Arizona or 28a-f show notified at within 72 hours after death with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 6356 Amherst Avenue 21046 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Master Sergeant U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Harlen Barron Grace Lou Price permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardella Barron (Wife) 6356 Amherst Avenue Columbia, Maryland 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cemetery 7-27-2012 Owings Mills, Maryland 21. Signature of Juneral Service Line nsee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Physician/ Medical Immediate Cause (Final Atherosclerotic Onset and Death coronary vasinlar disease resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical HESTE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day 1 Yes 2 9 Unknown the Hospitallor Attending Physician: The law requires that the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Horillation with pacemaker 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy lung disease 2 🗆 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 🗌 No 1 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be within 24 hours feer deatl To the Funeral Director. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie JU/4/9,2012 900 Caton Avenue Baltimore, MD 21229 Date filed (Mc Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 22 Day 2012 09:05a HAZEL Α. BOSTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/AMANOR CARE-ROLLING PARK BALTIMORE 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 220-32-5232 1 M 2 X F 79 Yrs. DEC. 19, 1932 MARYLAND Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Examiner must be notified ¹X☐ Yes 2 ☐ No BALTIMORE MARYLAND N/Aō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1751 E. NORTHERN PKWY 21239 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ŏ þ 1 Never Married 2 Married nan "natural", Medical Exar 1 ☐ Yes 2X No Specify: Specify: BLACK Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER **EDUCATION** 4yrs 12yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SARAH PARKER unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1751 E. Northern Pkwy., Baltimore, Md., 21239 Keisha Blye/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 07 - 28 - 12MT. ZION CEMETERY LANSDOWNE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service tipe WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Douer 1206 W NORTH AVENUE, BALTIMORE, MD., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): bur al-transit and Due to (or as a consequence of): resulting in death) Last attending physicial for use as the bur a Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth
Pregnant a
Unknown in the past 12 months?
1 ☐ Yes 2 📉 No Month Dav Year been signed by the a should be detached 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No al or Attending Physician: The safter death.

Director: After this certificate by 2 🗆 No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d 1210 SPRING BALTIMORE mo 603 STUNEY UMA DRIVE 31. Date filed (Month, Day, ^{Year)} 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary				/lental Hy	giene	010	221 (0
			Registrar 1. Decedent's Name (First, Middle, Last)	Cert	ificate of D	eath	2. Date of De	Reg. No.	012	23468
	Physicia Medic		Shelva Wright Bu	ırdette			4.4 11		Voor	3. Time of Death 3. Time of Death
1	Examin	er	4a. Facility Name (if not institution, give street and number) Frederick Memorial F	Hospital	4b. City, Town, or I	ocation of Death			y of Death rederi	ck
	Funeral Director		215-46-1873 1 DM 2 STE	, , , , , , , , , , , , , , , , , , ,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthplac Country)	e (State or Foreign
	nd how at	'n	Usual Residence of Decedent	72 Yrs. c. City, Town or Loca	ation		3/16/	1940	10d	MD Inside City Limits
	Maryla 28a-f s otified	Director	MD Frederick	Frederic	ck					1 ☐ Yes 2 🔀 No
	ith the 23a or st be r	ral	10e. Street and Number		10f. Zip Code			10g. Citizen of		?
	ems sems	Funeral	7042 Basswood Rd. 11. Marital Status 12. Was Decedent Ever	in U.S. 13. W	2107 as Decedent of His		ecify Yes or No-		DSA ce - American I	ndian
36	I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 X Married Armed Forces? 1 Yes 2 No If Yes, Give 1 Ver or Date:		as Decedent of His Yes, specify Cuban Yes 2 No		Rican, etc.)		ck, White, etc.	
9	hours natura tical E	olete	15. Decedent's Education		nt's Usual Occupat				White Business/Indust	
Baltimore, Maryland 21215-0036	thin 72 ene. than " he Mec	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	life. DO	nd of work done du NOT use retired) omemaker	ring most of work	ing		Home	.,
א פר בי	filed w al Hygi I othe i vent, 1	Be	17. Father's Name (First, Middle, Last)	1 110	·	18. Mother's Nam	e (First, Middle,			
Z Z	uld be I Menta narked natic e	To	Ralph DeWitt Wright			Margare	t Eliza	beth Da	yhoff	
Σ	12 should alth and Me 27 is mar r traumati		19a. Informant's Name/Relationship (Type, Print) Lewis Smith/Husband		Address (Street and Basswoo					e)
ore,	o = = =			0b. Place of Disposit			Date	20c. Location		State
	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Specify)	S. Carroll	l Cremato	ry 7/23			eld, M	
n D	Depz Impo any i		21. Signature of Funeral Service Licensee		Name and Addross 212 W. Ol					
)	hysician Medical Examiner	her	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition or successful to the conditions, and the conditions, and the conditions, and the conditions, and the conditions of the conditions, and the conditions of	E My	the mode of dying,				Inte	proximate erval Between set and Death
DIVISION OF VICE RECORDS, P.O. BOX 06/00	physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con							
). DOX 08/	ar death. ector: After this certificate has been signed by the attending pr by the funeral director, page 2 should be detached for use as t	~	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of prediction of the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 🔲 E	Ectopic pregnancy Other (s <i>p</i> ec <i>ify)</i>				ate of delivery onth Day	Year
S, F.O.	signed b		Part II. Other significant conditions contributing to death but no	t resulting in the und	derlying cause giver	n in Part I.		bacco use cont		use of death?
records,	as beer 2 shou	Completed by				4	24a. Was a autop	an 24b.	Were autopsy f	indings available
ב ב ב	ficate h		25. Was case referred to medical				perfor	med?	death?	
VICAL	is certi	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient	2 ER/Outpatient	_ Other	e of Death (Check		ence 6 🗆 Othe	er (Speciful	-
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VISIOII	er death ector: / by the	Certificate:	 			es 2 No	28f. Location (Si	reet and Number	er or Rural Rou	te Number,
בַּלָּבְּ בַּלְבָּ	ours afte		building, etc. (Spi				City or Town			
Hoot Hoo	To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my known only one) 3 Certifying Nurse Practitioner: To the best	nation and/or investiga	ation, in my opinion.	death occurred at	the time date ar	d place and due	to the causels) and manner stated.
Ę	To with		29b. Signature and its of certifier		29c. License n			29d. Date signed		
1	5V	- 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	Pecol	FLEOR	NIE	MD 2	1702	
	State Registra	e r	31. Date filed (Month, Day, Year) JUL 25 2012 32. Registrar's Si							

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joan M. Czawlytko 1:58PM JUL4 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE ST-AGNES BALTIMORE **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 215-18-5567 Months 1 □ M 2 🔀F 89 Director 2/22/1923 Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits must be notified 28a-f MD Baltimore Halethorpe 1 ☐ Yes 2X No or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1216 North Avenue 21227 USA 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 White If Yes Give 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. the Homemaker 12 Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Ziemkowski Martin Winiecki Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Valentine A. Czawlytko /spouse 1216 North Avenue, Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or of once. 1 XBurial 2 Cremation 3 Removal from State St. Stanislaus Ceme. 7/28/2012 Qonation 5 Other (Specify) Dundalk, Maryland n tun of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final disease or condition Physician/ PNEUMONIA Medical resulting in death) Examiner ASPIRATION UNKNOWN Securentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Certificate: To Be Completed by DEMENTIA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown SEVERE MITRAL REGURGITATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No HEART FAILURE CONGESTIVE Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours To the Funeral Medical 29a. Certifier 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. AVENUE BALTIMORE, MID 900 CATON State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mabel Elizabeth Cook 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospital Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. commercy land A 89th Pay, Year) 192 216-22-0539 88 1 🗆 M 2 🖾 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Marylan¢ Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 U.S.A. 2631 Hanover Pike 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary Katherine

Katherine Flizabeth zabeth Lawson Harry T. Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7225 Stratton Way, Baltimore, MD. 21224 Diane Dziemburski daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. July 26,2012 Frederick, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Hex Eller 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EN CEPHALODATHLY disease or condition resulting in death) Due to (or as a consequence of) CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a nonsequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Examiner sician and burial-transit attending physician or Attending Physician: The law requires that the death certificate be Box 68760 as the nse ō signed by the at Id be detached for Division of Vital Records, P.O. should I page 2 certificate funeral director, After this death. Hospital or Attendi 24 hours after death Funeral Director: A the ģ filled in

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Medical

Examiner

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Department of I Important: If it any injury or of once.

Priysician/

Medical

. Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Heath and Mental Hygiene. Hant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, If a Model Examiner must be notified at Jury or other traumatic event, If a Model Examiner must be notified at

Baltimore, Maryland 21215-0036

T % L %	Medi	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigal only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, der	tion, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner sta
To the within To the comple		29b. Signature and title of certifier	29c. License number 63	29d. Date signed (Month, Day, Year) 7-23-12
40		30. Name and address of person who completed cause of death (Item 23a) (Type, Print FRANCIS K. HOD 200 MEMOR A	LAVE, WESTMIN	15TER, MD 21157
State Registra	7	31. Date filed (Month_Day, Year) 32. Figure 1. Signature	KI	

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07 Carrington Mary Lazine 20 20T2 6:30a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Catonsville 4c. County of Death Baltimore Summit Park Health Care Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days 04 OI Hours Min. 227-32-7768 Director 82 VA Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21229 503 Lyndhurst Street within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc.
Black þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced al Hygiene.
ad other than "natural"
• the Medical F Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) mentary/Seconday (0-12) College (1-4 or 5+) City Hospital Dietician 12th grade 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Harris permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) Richard Davis 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number of Rural Route Number City of Jown State, Zin Code) 21207 Christine Joseph-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State King Memorial Park 7/28/2012 Woodlawn, Md 4 Donation 5 Other (Specify) Signature of Funeral Selvice I Marchd For Hof Welst 4300 Wabash Ave, Baltimore, Md complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . Enter the disease, or shock, or heart failure. List & one cause on each ine. Interval Betweer Immediate Cause (Final Onset and Death Pnysician/ 01 disease or condition resulting in death) YRUS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown ped signed by the be detacl significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of hours after death. uneral Director: After 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Hospital within 24 hours
To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the ba s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature who completed cause of death (Item 23a) (Type, Print) 3350 WILLCOMIC AUR #307 BALT. My

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month corge Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 132-32-4905 1 🙀 M 2 🗆 F May 31, 1942 New York 70 1 end 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "naturel", or items 23e or 28e-f show other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 8215 Stone Crop Drive Unit L 21043 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Attorney Maritime Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joyce Mortensen Ernest Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dearne Clements (Wife) 8215 Stone Crop Drive Unit L Ellicott City, Maryland 21043 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If its any injury or of 7-21-2012 Meadowridge Memorial Pk. Elkridge, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature | Fun ral Service Lio 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burlal-transit or Attending Physicien: The lew requires that the death certificate be executed resulting in death) Last Physician/Medical Box 68760 as attending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Other (specify) Day Year Pregnant at time of death signed by the a ld be detached f 1 Yes 2 9 Unknown 2 No g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, icate has been sig r, page 2 should b 1 🗌 Yes 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe To the Hospital or Attending Physiclen: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes |2 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

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State Registrar on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [™]Jul 17, 2012 11:25 PM W. Liller **Davis** Alice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Allegany Cumberland 1030 Brown Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth **Funeral** Days Oct 10 1916 Hours 217-10-5636 1 🗆 M 2 🔀 Director 95 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a -f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Cumberland 10b. Cour 10d. Inside City Limits Director MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21502 1030 Brown Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 white 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Rotruck 17. Father's Name (First, Middle, Last) 2 **Edward Liller** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (1913) 21502 19a. Informant's Name/Relationship (Type, Print) Arlene Connor daughter Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Wary's Cemetery or other place) 7/21/2012 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name ar **3 carpelli Furiteral Home, PA** of Funeral Pervice 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -UN Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be endeath out.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending inhusing. Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery Ectopic pregnancy in the past 12 mg Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sig page 2 should b 1 🗌 Yes 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes completely filled in by the funeral director, Be 25. Was case referred to dical examiner? 26. Place of Death (Check only one) 2 No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifie of death (Item 23a) (Type, Print) 25 Bishop Walsh Rd.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20°1 2 9:00a M Anne Marie Dayhaw Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll . Social Security Number If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday If Under 1 Year 1 M 2 X F Mayth, 9277 Year 1952 212-60-8421 60 Maryland Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No Maryland Carroll Manchester 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3066 Crown Circle 21102 U.S.A. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after 2**Y** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed Specify: 3 ☒ Widowed 4 ☐ Divorced White Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth John August Vogelpohl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 4302 Hanover Pike, Manchester, 21102 MD. Kimberly Dayhaw - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) July 20a. Method of Disposition 20c. Location - City or Town, State 2^{Date} 2012 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel Guth Tekholx 296 Dr. Manchester, 21102 Charmil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Betweer Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi to severe oslowth Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa this certificate 2 No 1 🗌 Yes Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work' 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check se Practioner: To the best of my knowledge, death occu rred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 Certifying Nug 29b. Signature and title

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Da

12-04632 John Darling Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Darling		1- For State Registrar	ate of Maryla		artment o ertificate o		d Mental		Reg. No. 2	012 2347
Physici Medical Exam		1. Decedent's Name (First, Midd John Mosher Da		· .			_	2. Date of De Month June 19,		3. Time of Death 1959 hrs
		4a. Facility Name (if not institution St. Agnes Hospital				4b. City, Town, or I Baltimore	Location of De	ath	4c. County o	f Death
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24h	1in.		Birthplace (State or Foreign
		218-54-7411 Usual Residence of Decedent	1 AM Z	62				Uuly 7	, 1949	Country) Maryland
d sow any		10a, State 10b, County Maryland Queer	n Anne's		y, Town or Loca					10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number	i Anne S	Criu	rch Hil	10f. Zip Code			10g. Citizen of Wha	
th the A		416 Church Hil				21623			USA	
eath wi	Funeral	11. Marital Status 1 Never Married 2 Maried	arried Armed Fo			as Decedent of Hisp es, specify Cuban,			0- 14. Race - White,	American Indian, Black, etc.
s after d ral", or	by F		orced If Yes, Give Yaa or Dates:		1 🗆	Yes 2 X No			Specify:	White
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Specific Elementary/Secondary (0-12)	cify only highest grad			nt's Usual Occupationst of working life.			16b. Kind of Bus	iness/Industry
0036 within 7 iene.	Completed		3	· .	Softwa	re Specia			Verizo	n
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fah injury or other traumatic event, the Medical Examiner must be notified at once	BeC	17. Father's Name (First, Middle,					8.Mother's Nam uth Fo		Maiden Surname)	
D 21 should the mad Mer is mark	卢	John Mosher Dan				Address (Street	and Number o	r Rural Route Nu		
e, MD 1 and 2 sho Health and item 27 is		Jacqueline Dar		20b.	Place of Dispos	Church H	etery,	ad Churc Date	h Hill, [MD 21623 City or Town, State
Baltimore, permit. Pages I as Department of He Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Sp			crematory or ot ntt Crei	matorv	6/2	26/2012	Waldorf	MD
Balti permit. Departi Import injury	J),	21. Signature of Funeral Service			22. N	lame and Address	of Facility F	eck Fune	ral Home	
Physician		23a. Enter the disease, or failure List only one cause	com lications that ca	used the death	n. Do not enter t	501 Sandy ne mode of dying, s	_ Spring uch as cardiad	G ROAG L or respiratory arr	est, shock, or hear	t Approximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)				lerotic (Cardiov	ascular	Disease	Between Onset and Death
1		Sequentially list conditions,	b							
ř,	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c.	III L COTT						
ecuted and transit	Exa	events resulting in death) Last	Due to (or as a d.	consequence o	of):					
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OX 6876 eath certificate attending phy for use as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of preg rth		tal death 3	Ectopic pregi	nancy	23d. Date of d Month	elivery Day Year
Box 6876 e death certificat the attending phy ed for use as the	Physiclan/N	1 Yes 2 No 9 Unk	nown 9 Unkno	ant at time of de wn	eath 5 Ot	ner (Specify)				
ires that the signed by the detached	by Ph	Part II. Other significant conditi	ons contributing to	death but not r	esulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
ds, F equires een sign								1Yes	2011	Probably 4 V Unknown ere autopsy findings available
Records, The law require ficate has been signated as the strength of the stren	Completed							autop perfor	psy pri- rmed? de	or to completion of cause of ath? Yes 2 No
tal Rectant: The	Be C	25. Was case referred to medical examiner?	Hospital:			T ₀	f Death (Check		2 10 1	7 165 2 100
of Vitaling Physician: After this certiuneral director	၉	1 Yes 2 No 27. Manner of Death	28a. Date o	of Injury	ER/Outpatient 28b. Time of Ir				Residence 6 how injury occurred	Other:
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Division tal or Attendi rs after death. al Director: A	Certification:		I not be mined (Specify)	of Injury - At h	ome, farm, stree	t, factory, office bui	lding, etc.	28f. Location (S or Town, S		or Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Ph	ysician: To the best	of my knowled	ge, death occur	red at the time, date	and place, an	d due to the caus	e(s) and manner a	s stated.
To the Ho within 24 P To the Fu	Medical	one) 2 Medical Exam 29b. Signature and title of certifier	niner: On the basis of and manner sta	examination a ated.	nd/or investigat	on, in my opinion, o		at the time, date		to the cause(s) (Month, Day, Year)
		Jamet Dush	will mi)		O.C.M			June 20, 201	1
		30. Name and address of person of Pamela E. Southall, M	11.12			\/\/ Baltimers	Street Bell	imore MD C	1222	
St	ate	31. Date filed (Month, Day, Year)			miner 900	W. Baltimore	otreet, Ball	imore, MD 2	1223	
Regist	rar	1111 2 5 2012	(Deere	J B.	APRILLE					

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harry E. Foster St. Month 10:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs.

Davs Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 226-42-4891 Director 1 № M 2 🗆 F 7/26/35 76 Virginia r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location Director 10d. Inside City Limits Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1409 Forest Hill Avenue 21230 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Painter Self Employed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 Is marked ott any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Frederick Foster Sr. Minnie Margaret Alger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita A. Foster / 1409 Forest Hill Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/23/12 Loudon Park Cemetery Baltimore, Marvland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee, 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure, just only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death End-Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunial-tran resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Specific how pice 1 ☐ Yes 2 ☐ No ရှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 20057465 7/19/12 SZO3 Relts more MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NS (WMPAUSEMD 2835 Smim AV

Registrar

25

12-05273 Samuel Foreman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	For State		te of Death	and Mental II	Reg.	No. 201	2 2347
Physicia Medical Examir		Decedent's Name (First, Middle,Last) SAMUEL ROBERT FOREMAN				2. Date of Death Month D July 13, 201	ay Year	3. Time of Death 0916 hrs
iledical Examin		4a. Facility Name (if not institution, give street and num	ber)	4b. City, Tow	n, or Location of Death		4c. County of Death	
		126 North Main Street	. Age (In yrs, last birth	Galena	Year If Under 24Hrs	s. 8. Date of Birth(Kent Representation	place (State or
Funeral Director		215-36-0827 1× M 2 F	72	* /	Days Hours Mir	—	Eorgian	
u	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o					10d. Inside City Limits
Aaryland 28a-f show	ō	MD Kent	Galer					1 X Yes 2 No
ith the Maryland 23a or 28a-f sho	I Director	10e. Street and Number 126 North Main St.		10f. Zip Co 2163	35	Ü	Citizen of What Count. S.A.	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Moore al Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed For 1 Yes		If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerton No specify:		14. Race - Americ White, etc.	an Indian, Black, nite
urs afte	d b	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade		ecedent's Usual Occ	cupation (Give kind of		6b. Kind of Business/Ir	dustry
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21215-00; uld be filed with Mental Hygiene marked other t	Be	John Noah Foreman	I said				Nickerson	
MD 2 ad 2 should ulth and M m 27 is m aumatic c	۵[19a. Informant's Name/Relationship (Type, Print) John Foreman (bro		, Mailing Address (S 3531 Broad			er, City or Town, State,	
Baltimore, ME pemit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:	Ì	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from	cremator	Disposition (Name or ry or other place)		Date 2	0c. Location - City or 1	own, State
Baltimore, permit. Pages I an Department of Hec Important: If ite		4 Donation 5 Other Specify: 21 Suppositure of Funeral Service Licensee	Odd F	'ellows Ce	-	21/12	Smyrna, D	
Bal permi Depar Impo injur		2 and Solving Element	M00510	118 Wes	Funeral Ho t Cross St	me of Ste . Galena,	ephen L. Sc MD. 21635	haech
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Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclero	tic Cardiovascula onsequence of):	ar Disease com	plicated by Hype	rthermia		Deau
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6876 ertificate ding phy	an/M	3b. Was decedent pregnant in the		Fetal death	3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	nt at time of death 5	Other (Specify)				
P.O. B that the d	2	Part II. Other significant conditions contributing to	death but not resulting	in the underlying car	use given in Part I.		cco use contribute to to	
cords, Plaw requires that been sign 2 should be contact.	Completed					24a, Was an autopsy		opsy findings available ompletion of cause of
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n of Vital Rec Jing Physician: The After this certificate funeral director, page	유	1 Yes 2 No 28a Date o	f Injury 28b T	tpatient 3 DOA	Injury at Work?	28d. Describe hov		
vision or Attendin er death. Director: A n by the fun	ation	1 Natural 5 Pending FOUND: 2 ✓ Accident Investigation		1 .	Yes 2 ✔ No		xtreme environme	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sale of death. 11 Director. After this certificate has been signed by led in by the funeral director, page 2 should he detack.	Cert fication:	3 Suicide 6 Could not be determined (Specify)	of Injury - At home, far Single Family Ho		fice building, etc.	or Town, Stat	eet and Number or Rur e) eet, Galena, MD	al Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours a er death. To the Funceral Director. After this certificate has been signed by the attending prompletely filled in by the funceral director, page 2 should he detached for use as the	Medical Co	29a. Certifier 1 Certifying Physician: To the best (Check only one) Physician: To the basis of	of my knowledge, deat examination and/or in	th occurred at the tim		d due to the cause(s	s) and manner as state	
To Signature	Me	and manner sta	neu.		cense number		29d. Date signed (Mon	th, Day, Year)
70.1		Pencely without, MI		0	O.C.M.E.		July 14, 2012	
131		30. Name and address of person who completed cause Pamela E. Southall, MD Assistant N	of death (Item 23a) ledical Examiner	900 W. Baltir	nore Street, Balt	imore, MD 212	23	
St Regist	ate rar	31. Date filed (<i>Month, Day</i> Year) 32. Rec	strar's Signature					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 1tems 10b, c, 19b per 1h g929 7-25-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ seve Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Samaritar Baltmore Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 220-36-5977 Hours MD **Director** 1 M 2 □ F Yrs JUly, 14,1941 Usual Residence of Dec 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD N/ARandlestown Yes 2 No Balto. Randallstown Street and Number 10f. Zip Code 10g. Citizen of What Country? 9208 Allenwood Rd 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African Specify:Amer. þ 1 Never Married 2 Married 1 Yes 2 No Specify. 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Driver Be 17. Father's Name (First, Middle, Last) Gordan Fisher 18. Mother's Name (First Middle, Maiden Surpame) Clara Bulter Fisher 19b. Mailing, Address (Street and Number or Rural Route Rands 1 town, State, Zip Code)
12 Vivian Vale Court, Randlestown, MD 21₁33 ^{19a.} Informant's Name/Relationship *(Type, Print)* Kathy Alexander/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State 7/23/12 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. 5126 Belair Rd, Balt: 21. Signature of Funeral Service Licensee Close F6SysoBA 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician ! disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown been signed by the a should be detached t Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension, chiabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? renal diseas 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) xaminer? Other: 2 \square No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title 9 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 0 Date filed (Mo State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death FROCK RUBERT Year Physician/ 10:40 AM TULY 20 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TRANSITIONS YILESVILLE CAMOLL HEALTH CARÉ If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Months Hours 1 X M 2 🗆 F 214-12-8385 Maryland Director 91 March Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Ellicott City 1 Yes 2 No MD Howard 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21042 USA 10030 German Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, et 1 ☑ Yes 2 ☐ No If Yes, Give "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 Midowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Local 486 10Steamfitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Azalea Williams George W. Frock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Frock Daughter 10030 German Road; Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 7/30/12 Garrison, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funzal Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final DEMENTIA Physician) disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 🗆 Yes 2 🗆 No 1 ☐ Yes 2 🔽 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 ☑ No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) ひょファンユ M.D. 2012

0/x

DHMH 17 Rev 7/2009

Registrar

M.O. 1838 GREENE THEE RUAD #300 PILLESVILLE MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EONARD RICHARDSON

31. Date filed (Month, Day, Year)

			State Registrar			Certi	ificate o	f Death			Reg. N	0.			
	Physicia	n/	1. Decedent's Name (First, Middle, La							2. Date of De		ay Ye	ar	3. Time of Death	
	Medic	al	Alice	J. Gross						07/		2012		3:30 A	VI
	Examin	er	4a. Facility Name (if not institution, giv St. Martin's Hor				4b. City, Town Cator	i, or Location ISVILL			1	c.County of D Baltima			
	Funeral	-	Social Security Number 6. 8	Sex 7. Age	(In yrs. last bi		If Under 1 Ye	ar If Und	er 24 Hrs.	8. Date of Bir	th	9.		ace (State or Foreig	ın
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	nd now at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loca	tion						10	d. Inside City Limit	c .
	arylar a-fst fied	Director	MD Baltimo		-	nsvil								1 🗆 Yes 2 🕱 N	
	the Mor 28		10e. Street and Number	,			10f. Zip Coo	e			10g. C	itizen of What	Countr		_
	with s 23a ust b	Funeral	601 Maiden Choice	e Lane			21	228				USA			
	death item		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.		s Decedent o			cify Yes or No- Rican, etc.)		14. Race - A Black, W			
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 Yes 2 K N	lo	1 [Yes 2 🗶	No Specia	fy:				Whit		
Š	s filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's I		166		nt's Usual Oc				16b.	Kind of Busine	ess Indu	ıstrv	_
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Maryland 21215-0036	ould be file d Mental H marked of matic ever	To B	17. Father's Name (First, Middle, Last) Arthur Murphy							e (First, Middle, Nordt	Maiden	Surname)			
a _Z	2 should be th and Men ?7 is marke traumatic	n 3	19a. Informant's Name/Relationship (Type, Print)	19					l Route Numbe			, Zip Co	nde)	
	1 and 2 soft Health item 27 other tra		Edward P. Gross	/ Son		1385	Karens	way,	York	, PA 17	7402				
nore		1	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		cemet	ery, crema	tion (Name of tory or other Corest	olace) Cem		Date 27/2012		ocation - City			
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licer	see		22. 1	Name and Ad	dress of Fac	ility Huk	bard Fi	ıner	al Hom	e, :	INc.	
11	9 Q T P 9	1		aniel Simon		4	107 Wi	Lkens	Ave.,	Baltir	nore	, MD 2	1229	9	_
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ROX	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician	in the past 12 months? 1 ☐ Yes 2 🖾 No	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			ctopic pregr Other (specify					Month		Day Year	
<u>.</u>	t the (Phy	9 Unknown Part II. Other significant conditions		t not reculting	in the und	lark in a carrer	- siyan in Da	- 1						_
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Vital Records,	requir been s should	letec	HYPERTENSIVE	CARALLAC	17 42 ·	2 01	NE	TROP	ATHY	24a. Was				sy findings available	
ပ္ပ	sician: The law i certificate has b irector, page 2 s	duic	ALZHEIMER'S	DEMENTA	A CH	C_{0}	SE HUE C ATR	PH	EUM	Delle	psy ormed?	prior death	to com	pletion of cause of	,
<u>~</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical	EMENTA	n, err	KO MI		Place of De	eath (Check	Only one)	2 DXN	lo 1 🗆	Yes 2	∐ No	_
<u> </u>	nysici nis cer i direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatier	nt 2 🗆 ER/C	outpatient	3 🗆 DOA	Other: 4 🔀	Nursing Ho	me 5 🗆 Resid	dence (6 ☐ Other (S)	pecify)_		
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200	ttend death stor: / the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not l	oe 280 Place of Injur	v - At home f	arm etraci		Yes 2	No	206 Leoption //	Taxona or	and Alexandra v a v	Dinal D	Parita Alimahar	_
Division of	al or A s after I Direct	_	4 Homicide determined	building, etc.		arm, street	i, ractory, one	,	Į	28f. Location (8 City or Tov			nurai n	oute Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	rsician: To the best of miner: On the basis of exa	ny knowledge amination and/	, death oc	cured at the t	me, date an	d place, an occurred at	d due to the ca	use(s) a and place	ind manner as e, and due to t	stated.	e(s) and manner sta	ted
	o the ithin 2 or the omple	Ĭ	only one) 3 Certifying Nur 29b. Signature and title of certifier	rse Practioner: To the b	est of my knov	wledge, dea		t the time, da		e, and due to th		(s) and manner ate signed (Mo			_
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	•		30. Name and address of person who	- FLOW	ath (Item 23a)	(Type, Prir		- 1				1=1	- 01		_
			Dr. Komal Dang,				08, Ba	ltimor	ce, M	21229					
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrat	s Signature	1									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month enneth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MV Trauma . Social Security Number 187-52-0344 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Director 54 1 XM 2 □ F 08/19/1957 Yrs Pennsylvania Usual Residence of Decede 28a-f show at 10c. City. Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f sidical Examiner must be notified PA Allegheny West Mifflin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Oxford Drive 15122 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Completed White er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Manufacturing Welder Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th once. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lawrence E. Guidish Carol Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Guidish 108 Oxford Drive West Mifflin, Pennsylvania 15122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lebanon Cemetery 07/24/2012 West Mifflin, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel michael 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 14 hrs Think Sequentially list conditions, if any leading to immedia cause. Enter Underlying Cause (Disease or injury Examir rowning With -tran and that initiated events resulting in death) Last PHOLED BY MEDICAL EXAMINES Due to (or as a consequence of): burialthe attending physician the driving the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 3 Ectopic pregnancy
5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗌 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ပ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Body Sertine 1030 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: It this best of my knowledge, ceath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amos S_{-} Baltimore, mo 22 Greene St

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 5 2012

32. Registraris Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5, per fh. g930 8-10-12 sm
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARIE GRAMMER Medical ЛЛ У 2012 254 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MARYLAND MASONIC HOME BALTIMORE COUNTY BALTIMORE 8. Date of Birth (Month, Day, Year) Social Security Number 219-16-7849 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 M 2 W F Country) Director 94 Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Baltimore County 1 🗌 Yes 2 🙀 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 7900 Babikow Rd. 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 🎗 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed XX Widowed 4 Divorced Specify: White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home <u>12th arade</u> e 1 and 2 should be filed wir of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William W. Watchman Marie Auer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17201 Pretty Boy Dam Rd. Parkton, Md. 21120 William Billett (Son) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 7-25-2012 Baltimore, Md. Someture of Funeral Service Lipansee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home 21236 Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CAR DIUV disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to or as a consequence of if any leading to impro-cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 1 Yes 2 D signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral D Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIBERTU Ms.

Registrar

J DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

12-05517 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Marvin Edward Gartrell State of Maryland / Department of Health and Mental Hygiene 2012 23484 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death July 23, 2012 **Medical Examiner** Marvin Edward Gartrell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Carrol Hospital Carroll Carroll 5. Social Security Number 6. Sex 7, Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Min. Director 215-26-1218 1 X M 2 F 1931 Jan 11 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show a notified at once. MD Carroll Mt. Airy Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2142 Flag Marsh Road 21771 US Funeral 11 Marital Status Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 X Married If Yes, Give Year 1952 - 551 Yes 2 X No specify: 4 Divorced Specify. ۾ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sign Foreman 12 State Highway Admin 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Tolley Edward Gartrell Amanda Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erma Jane Gartrell - Wife 2142 Flag Marsh Road, Mt. Airy, Md 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department or Important: I Morgan Chapel Cem Jul 27 2012 Woodbine, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Burrier-Queen Funeral Home 21. Signature of Funeral Service 1212 West Old Liberty Road, Woodbine 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last ned by the attending physician and detached for use as the bunal - transi ca UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown To the Hospital or Attending Physician: The law requires that the whin 24 hours after death.

within 24 hours after death.

Che Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be dreaheded. 屳 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performe death? 1 Yes Yes 2 ✔ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 2 No 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide

1712 hrs

10d. Inside City Limits

1 Yes 2 X No

White

Approximate Interval

Between Onset and

Year

2 No

Day

29d. Date signed (Month, Day, Year)

July 24, 2012

Country)

흅

Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) State Registrar

01

Homicide

29b_Signature and title of certifier

ar's Signature

Assistant Medical Examiner

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a)

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ANNA GRIFFITH 292 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UESTMINSTER CARROLL DOVE CARROLL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth cial Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 95 Director 220 09 0549 1 - M 2 X F 1917 MARYLAND ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CARROLL 1 🗆 Yes 2 🕅 No SYKESVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral 21784 USA RINGE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. parmit. Paga 1 and 2 should ba filad within 72 hours aftar d Department of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or i any Injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Romoser OUISE RAYCOB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYKESVILLE IND 21784 NILLIAM J. GRIFFITH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEAROURINGE M. PARK 7/28/2012 ELKRIDGE, MO 21. Signature of Funeral Service Licensee

22. Name and Address of Facility | W ZVMBW 6028 SYFESVILLE RV ELWE

23a. Nart V. Enter the disease, or complications that caused the death. Do not ent r the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line 22. Name and Address of Facility J W ZUMBWW/=1+8 MONCO 6028 SYKESVILLE RO ELNERS BURG-MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediat cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of signed by tha attanding physician and d ba detachad for usa as tha burlal-transit To the Hospital or Attending Physician: The law requires that the death carlificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ₺ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. | significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 2 🗗 1 🔲 Yes 2 1 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence NPHILE 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nu/se Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only e and title of certifie 29b. Signa 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, State 5 Registrar

12-05407	
Lionel Green	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

ionel Green		- For State Registrar	State	e of Maryla		artment d <i>rtificate d</i>	of Health an of Death	id Mental i		eg. No. 20	12 2348
Physician Medical Examine	7	1. Decedent's Name	•	ast) E. Gree	n				2. Date of Deal Month July 18, 20	Dav Year	3. Time of Death 2008 hrs
Medical Examine		4a, Facility Name (if	not institution, g	give street and nu			4b. City, Town, o	r Location of Dea		4c. County of De	ath
Foreset	4	Union Memo 5. Social Security Nu	·	Sex	7. Age (In yrs.	last birthday)	Baltimore	ar If Under 24H	rs. 8. Date of Bir	th(MM/DD/YYYY) 9.1	Birthplace (State or
Funeral Director		215-90-8	527	M 2 F	4.8	•	Months Day		in		eign
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s after or iral", o	ል -	3 Widowed 15. Decedent's Edu		ed If Yes, Give Yes or Dates:	ar	11	Yes 2X No	10000	f work done	Specify: B1	
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Baltimore permit. Pages 1 Department of H Important: If in	- 14	2 e o	eral Se Lice Lic	entite-	2	27	Name and Address alvin B	ss of Facility Scruce Drogton	ggs Fun	eral Home	e 21213
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		/Medic Examin		4a. Facility Name (If not institution, gi		oer)		4b. City, Town,	or Location of De		4c.	County of D	eath	JM.
				Courtland Gard	ens Nur	sing	Home	Pikesv	ille		Ва	altimo	ore	
	P	Funeral			Sex 7. 1⊠M 2□F		last birthday)	If Under 1 Yea Months Day:			lirth Day, Year)	9.1	Country)	(State or Foreign
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	0	land		10a, State 10b. County		10c. Cit	ty, Town or La	ocation					10d.	Inside City Limits
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119/184	<u> </u>	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 '4 □ Donation 5 □ Other (Spec			cemetery, crei LYV1eW	osition (Name of matory or other pi Crema	tory 07	/30/12	Balt		e,Ma	ryland
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Amos Gassaway Harvey 2012 5 30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore FRANKLIN Rosedal € Saucese HOSPITal 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/19/1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours Min. Maryland 216-28-9773 81 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at Director 10d, Inside City Limits Maryland Baltimore 1 🗌 Yes 2 🄀 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 7522 Rossville Boulevard 21237 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. ō, þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black "natural", Completed 3

Widowed 4 □ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry State (Give kind of work done during most of working life. DO NOT use retired) of Maryland Health Elementary/Seconday (0-12) College (1-4 or 5+) Department 11th grade Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ಲ Charles Irvin Harvey Eunice Whims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906Gwendolyn Henderson 2607 Camelback Lane Unit 10 Silver Spring MD HなにVC、 Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 07/29at/12 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Long Green, Maryland Mt.Zion AME Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fluneral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore Maryland 21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician dementia Advance disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, neumoni Examine ue to lor as a consequence of cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) and the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IE FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 1 Yes 2 D the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aheumatoid Leukopenia 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a, Was an 1 ☐ Yes 2 ☐ No Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 3 No 욘 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 \(\sum \text{ Yes} \quad 2 \sum \text{ No} \) 1 Natural 5 Pending ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year, 20064167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square noshin Balto Quis DR 31. Date filed (Month, E 32. Registr#'s Sign; State Registrar

HDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 41AN Hubbard I. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1111 Plover Drive Halethorpe Baltimore If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 213-30-7470 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ☐ M 2**XX**F Julyonth, Pay Year 1933 79_{rs.} MaryTand Director Usual Residence of Decedent 28a-f shov 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Maryland Baltimore Halethorpe 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1111 Plover Drive 21227 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 XXMarried ☐ Yes ※XX No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify.White "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic John Kraft Miller Helen Cassandra Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Kramer/ Daughter 1111 Plover Driver, Halethorpe,Maryland 21227 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 5 Other (Specify) Glen Haven Mem. Prk. July 24,2012 Glen Burnie, Maryland 22. Name and Address of FaciAMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P,O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the atte Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 2 **N**o 1 Yes 25. Was case referred to medica filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b. Signature and N 9

DHMH 17 Rev 7/2009

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type,

Michael A.N 31. Date filed (Month, Day, Year)

2 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Charles Richa	d H	Offa 1- For State Registrar	State o	f Marylar		artment of rtificate of			Menta	al Hyg		eg. No.	2012	234
Physician/ Med Exam		1. Decedent's Name (Firs Charles R		Hoffa							Date of Dea Month July 18, 2	th Day 7/19/2	ar	of Death hrs
		4a. Facility Name (if not in Upper Chesapeake			er)	1	4b. City, To Bel Air	wn, or Lo	ocation of (Death		4c. County o Harford	f Death	
Funeral Director		5. Social Security Number	A.F.	vl 2□F	. Age (In yrs. I		If Under Months	1 Year Days	If Under :	24Hrs. Min.		th(MM/DD/YYYY)	Country)	
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136 hin 72 hours afte e than "natural",	ted	15. Decedent's Education Elementary/Secondary		College (1-4		16a, Deceden during m	i's Usual Oc ost of worki					16b. Kind of Bus	iness/Industry	
5-0036 led within 72 Hygiene other than	Completed	12		2	·	Con	tract	s Ma	nagei	r		Northro	p Grum	nan
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 72 hours after death Operanter of Health and Mental Hygiene. Inportant: It ferm 27 is marked other than "natural", or iten injury or other traumatic event, it wite its it was naturals.		17 Father's Name (First,						18				laiden Surname)	_	
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Page Page ment o tant:	١,	4 Donation 5 C	Other Specify			tro Cre	mator	у,	Inc. (07/2	1/2012	Baltimo	re, Ma	ryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filled within Department of Figuilan and Anstal Hygene Important: If term 27 is marked other it injury or other traumatic event, it who		21 Signature of Funeral	\checkmark			22. N	ame and Ad	dress of	Fecility I	E. F	. Lass	Baltimo ahn Fune	eral Ho	me, P.A.
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Box 687 be death certific the attending prode as the	sicia	1 Yes 2 No 9	Unknown	4 Pregnar	nt at time of dea	ath 5 Oth	er (Specifi	y)						
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Division of Vital Records, pial or Attending Physician: The law requires at the reduit certains. The law requirement of the result of the resu	Certification:	3 Suicide 6	Could not be	28e. Place o	of Injury - At ho	ome, farm, stree	t, factory, o	ffice build	ding, etc.		f. Locetion (S	treet and Number tate) Kingsville		
Dospital hours unerally filled		4 Homicide 29a Certifier 1 Certif	determined	7	Single Fam						Vista View	Court		
Division of Vital Records, P.O. Box 687 To the Hosp £al or Attending Physician: The law requires that the death certific within 24 hours after death. When Puneral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only	cal Examiner: O	n the basis of e	examination and							s) and manner as: d place, and due to		
T Wil	Me	29b Signature and title of		nd manner state	eu		29¢. L	icense n	number			29d. Date signed	(Month, Day,	Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LAWRENCE E. HARE, SR. Month Year 20 2012 Medical IIII Y 3:15A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death
BALTIMORE TOWSON GILCHRIST CENTER 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** April 7, 1918 Months Days Hours Min Director 220-03-6983 94 1**X**XM 2 □ F Yrs. Usual Residence of Deced 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Eranin, it must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector Baltimore County 1 Yes 2XXNo Baltimore Maryland Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 4224 Slater Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XX No Specify. Specify: White Completed XX Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Food Industry Deli Manager N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith end Mental H 27 Is marked of ၉ Elizabeth Strehlen David C. Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 4115 Link Avenue Baltimore, Md. 21236 ge 1 and 2 sh It of Health e If item 27 Is Virginia Brashears (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Importent: If eny Injury or once. 7-24-2012 4 Donation 5 Other (Specify) Gardens of Faith Baltimore, Md. 21. Signature of Emeral Service Idensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ MyocardeA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires thet the death certificate be executed attending physician and I for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was dece dent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) Month after death.

Director: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 300 ည hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral C completely filled Hospitai Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES M 6701 N Charles 31. Date filed /Ma 32. Registrar's Signature State Registrar

M DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0743 AM 2012 Medical 4a. Facility Name (if not institution, give street and 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Greatge Cheverly Hospital Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min NOV. I'S Vfrginia 91 Director 578-16-4665 1**X** M 2 □ F Vrc Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1X Yes 2 □ No Prince George's Ft. Washington Md 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20744 USA 1735 Rhodesia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status ıral", or iten I Examiner ı Armed Forces? 1 X Yes 2 \(\sum_{No} \) Army Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) e 1 and 2 should be filed within 72 l c of Health and Mental Hygiene. If item 27 is marked other than "n r other traumatic event, the Medi Elementary/Secondary (0-12) College (1-4 or 5+) Government Bus Driver 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arlene Jordan William Lloyd Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1735 Rhodesia Avenue Ft. Washington, Maryland 20744 . Page 1 and 2 sh Iment of Health ar tant: If item 27 is Aletha Barham/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
FT. Lincoln Cemetery 7/24/2012 ± 5 Department of Important: If any injury or Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral 22. Name and Address of Facility J. B. Jenkins Funeral Home, Inc. Landover Road Hyattsville, Maryland 20785 23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Onset and Death Stroke Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if an Jeading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last aftending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 certificate has Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 Yes Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 🗆 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретельно (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

4V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LRFAN M. KHURRAM: 3001

32. Registrar's

31. Date filed (Month, Day, Year)

D73283

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY P8 20°12 4:45P M ANN HWILKA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES 12 BLACKPOOL CIRCLE WALDORF Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. MAY 9, 1935 Director 224-42-9890 77 VA Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c, City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Directo CHARLES MD WALDORF 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 20602 12 BLACKPOOL CIRCLE S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🖺 No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3
Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) BUFORD CARR GRACE TRIMBEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD HWILKA/SPOUSE 12 BLACKPOOL CR., WALDORF, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State MD VETS.CEMETERY 7/.25/2012 CHELTENHAM, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) onces Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IE ESMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown P.O. signed to Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy page 1 ☐ Yes 2 ☐ No Yes Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death, 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending s after death.

I Director: Afted in by the fur 2 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 6 V ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of Ma	ryland /		rtment of H			iene 201	2 23494
	Physici		1. Decedent's Name (First, Middle, Las	B		1E	MER		2. Date of Deat	Day 2 Yea	3. Time of Death
7	/Medic Examin		4a. Facility Name (If not institution, give Vantage House	street and number)			4b. City, Town, or Columb	ia			ward
	Funeral Director		5. Social Security Number 6. Security Number 221–07–7979 1 Usual Residence of Decedent	X 7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, August 13	9. 8 1912 Ance	irthplace (State or Foreign Country) US Territory on Councel Zone
	death with the Maryland rme 23e or 28a-f ehow runth be notified at	tor	10a. State 10b. County Maryland Howard		10c. City, T	own or Lo				0	10d. Inside City Limits 1 ☐ Yes ②☑No
	with the	Directo	10e. Street and Number	D 1			10f. Zip Code	2//	1	0g. Citizen of What	Country?
350	n 72 hours after death with the Marylan "natural", or iteme 23e or 28e-f ehow edical Ezandrar man be rediffed at	by Funeral	5400 Vantage Point 11. Marital Status 1 Never Mamed 2 Married 3 Widowed 4 Divorced	I KOAO 12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba		Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - Ar Black, Wi	nerican Indian, nite, etc. White
9500-61212	within them	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		→)	U.S. G	lent's Usual Occupion of work done of the control of work done of the covernment; oan Bank	ation during most of wo Federal	rking	16b. Kind of Busines	,
Maryland	at a b	To Be C	17. Father's Name (First, Middle, Last) Floyd Heimer				n ry g	18. Mother's Na Zoe Harr	me (First, Middle, i ye	Maiden Sumame)	
Mar	and and is m		19a. Informant's Name/Relationship (1) Timothy Schwartz	Type, Print) (Guardian)						r, City or Town, State nesda, MD 200	11
Baitimore,	ages 1 and 3 ant of Health It: If Item 27 y or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		e of Dispos etery, cren	sition (Name of natory or other place ematory			20c. Location - City Glen Burnie	or Town, State
Baltil	permit. Pages 1 Department of F Important: If its eny injury or ot		21. Signature of Funeral Service Licen	200	101051	22	Name and Address		itzke Funer Columbia	al Homes, I	nc.
1,097	cate be executed hysician and hysician sit whysician and hysician sit while building the principle of the pr	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c. Due to (or as a c. Due to (or as a c.)	e. a consequent a consequen	ice of):	Hen A7			esi,	Approximate Interval Between Onset and Death
O. Box 68	it the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the birth appropriate and the programment at a position of the birth and the programment at the position of the birth and the birth	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
٦.	juires that the signed by ald be detacted	by	Part II. Other significant conditions of	ontributing to death bu	ut not resultir	ng in the ui	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Anknown
Records,	The law requires that the cate has been signed by the page 2 should be detached.	Completed							24a. Was a autop: perfor	sy prior death	
on of Vital	ng Physician: viter this cerulic uneral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie	y 28	VOutpatien Bb. Time of Injury	28c. Injur Wor	er: 4 Nursing	-	ne) CGC lence 6-Other (S ow injury occurred	pocity)
Division		Certification:	3 Suicide 6 Could not b		ry - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	examination	edge, death	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	e, and due to the curred at the time, o	cause(s) and manner date and place, and d	as stated. due to the cause(s)
•	To the within To the comple	Med	29b. Signature and title of ce tiller	/			29c. Licens			29d. Date signed (Me	
	10		30. Name and address of person who 300 ALNOR	completed cause of d	eath (Item 2:	За) (Туре, 7 <u>—</u>	Print) /CE	NE	14 6.	Mos	1201-
	Sta Regist	ate rar	31. Date filed Month, Day, Year)	32. Registra	ar's Signatur						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paula Lee Jackson Month 2012 12:34a M Medical 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice Examiner 4b. City, Town, or Location of Death TOWSON 4c. County Prathore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8 Date of Birth Days Hours (Month, Day, Year) 219-86-1860 1 🗆 M 2 🖾 Director 80 63 49 Yrs 06 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Randallstown MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 8802 Allenswood Road U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chesapeake Elementary/Secondary (0-12) College (1-4 or 5+) <u>12th grade</u> <u>2yrs</u> Financial Coordinator Neurology Assoc. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paula White William M. Watford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Jackson-Husband 8802 Allenswood Road, Randallstown, Md 21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 7/30/2012 Baltimore, Md 21. Si matu of Funeral Service License March and Address of Facility 300 Wabash Ave, 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause or Immediate Cause (Final at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Physician MOTASTATIC disease or condition GARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Finter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day ate has been signed by the a page 2 should be detached g 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an this certificate perform 1 ☐ Yes 2 ☐ No 2 No Physician: director, 25. Was case referred to medical 쏆 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specifity TOSPICE 2 🕒 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral di 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

2 5 2012

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State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland		artment of Hear tificate of Deat			giene _{Reg. No.} 20	112	23496
	Physicia		1. Decedent's Name (First, Middle, La Mary	Elizabet	h	Jackson		2. Date of Dea Month O 7	Day	Year 012	3. Time of Death 11:30a M
	Medic Examin		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, or Locat			4c. County	•	1 11.50a
1200	Formand		Milford Manor 5. Social Security Number 6.8		et hirthday)	Baltimo:	re nder 24 Hrs.	8. Date of Birt		G Birthe	place (State or Foreign
	Funeral Director		215-40-3411	□м 2ХГ 84	Yrs.	Months Days Hou	urs Min.	8. Date of Birt (Month, Day 09 16	, Year) 27	Coun	SC
	aryland a-f show ijed at	Director	Usual Residence of Decedent 10a, State 10b. County MD NA		,Town or Loc					1	0d. Inside City Limits
	the Ma or 28a e notif	P.	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Cour	
	th with	Funeral	5400 Crismer A			21215			U.	S.A	•
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If	Vas Decedent of Hispanio Yes, specify Cuban, Mex Yes 2 XNo Spe	xican, Puerto	ecify Yes or No- Rican, etc.)	Black	- Americ k, White, k Blak	
15-0	72 hou n "natu ledical	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give k	ent's Usual Occupation ind of work done during i ONOT use retired)	most of worki	'ng	16b. Kind of Bu		dustry General
212	within giene. er than	S	Elementary/Seconday (0-12) 12th grade	College (1-4 or 5+) na		ipervisor			Hospit		Jenerar
and	ntal Hy ed oth	_	17. Father's Name (First, Middle, Last) Oliver McRaven			1		e (First, Middle, ha Rob	Maiden Surname,)	
aryl	hould the land Me something was mark		19a. Informant's Name/Relationship (1	ype, Print)	19b. Mailin	g Address (Street and Nu				ate, Zip C	ode)
Σ,	tnd 2 sleatth a lealth a leafth a leaft	Ì	Margaret Jackso			Shorepoint	Ct.	#202,			
nore	age 1 a ant of H		20a. Method of Disposition ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	emetery, crem	sition (Name of eatory or other place)	İ	Date / 2012	20c. Location -	,	•
Baltimore, Maryland 21215-0036	permit. P Departme Importar any injur	İ	21. Signature of Funeral Service Licen	1,1 1111	м²á	Memorial	e yt		Arbutu		
	<u> </u>	4	23a Part 1 Enter the disease or com	D. Tell		00 Wabash				Md 2	
^	Physician/		23a. Part 1. Enter the disease, or com shock, or hear failure. List only of Immediate Cause (Final disease or condition	a. END STAGE							Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a conseque	ence of):	Transf Cherry	C:-1	0.00/1.			1
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):					-	
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0	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a conseque	ence or):						
68760		Medi	IF FEMALE:	- u							
Box 6	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delive oth	ery Day Y ear
Records, P.O. Box	uires that the des n signed by the a ld be detached f	ا ۾	Part II. Other significant conditions of	ontributing to death but not resu	Ilting in the ur	nderlying cause given in F	Part I.				e cause of death?
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/ital	Physician: Tr this certifica	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ B	- 	_ lother	Death (Check		ence 6 🗆 Othe	(Cassiful	
n of	ding Phy h. After this funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	2		ow injury occurre		
Division of Vital	ial or Attendii s after death. al Director: Al ed in by the fu	Certificate:	2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ne, farm, stre	_		28f. Location (S City or Town	treet and Number n, State)	r or Rural	Route Number,
٥	bours a	Medical (29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	edge, death o	ccured at the time, date a	and place, and	d due to the cau	se(s) and manne	r as state	d.
	To the Hos within 24 hc To the Fund completed	Me	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nur 29b. Signature and title of certifier	iner: On the basis of examination se Practioner: To the best of my	knowledge, d	gation, in my opinion, dear eath occurred at the time, 29c. License numb	date and place	e, and due to the	cause(s) and mar	nner as sta	ited.
	F > 5		organization and trade of partition	ll m.	p.	DS77		,	29d. Date signed		3 2012
	`		30. Name and address of person who	Sampleted source of death (Items)	02-) (Time D	etent)		11 D 1			
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	858 G1	CEENE TIWE	CAWN	#300 P	TILESVILL	, r	10 21208
	Registra	r	յսլ 2 5 2	012 Symus	a. 190						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kaminsk iam 2220 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY ST. AGNES HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) Hours 216-14-0326 11/17/23 **Director** 1**X** M 2 □ F 88 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 1 Yes XX No MD BALTIMORE CATONSVILLE 10e. Street and Numbe ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o with t Funeral 6348 FREDERICK ROAD 21228 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: WHITE Completed 3 ☐XWidowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working r than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) UNK. UNK. INDUSTRIAL WORKER SANITATION is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ဂ Page 1 and 2 should be ment of Health and Ment UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSLYN COOLEY PRAYER- GUARDIAN 611 CENTRAL AVE. TOWNSON, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🌠 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) MEADOWRIDGE 7/20/2012 ELKRIDGE, MD 22. Name and Address of Facility SKARDA FUNERAL HOME MO1120 HUDSON BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset a Death Immediate Cause (Final Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last as the burial-tran been signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat

Registrar

5

(Item 23a) (Type, Print)

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [™]ϽΰΙ 19, **2**Ό12 6:00 AM M Donald Kastner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 235 Paca St. Apt. 906 Cumberland Allegany Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country MD **Funeral** 8. Date of Birth 215-20-5920 Nov 20 1927 1 M 2 D F 84 **Director** 28a-f shov of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Cumberland 10d. Inside City Limits Director MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 235 Paca St. Apt. 906 21502 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status

1 Never Married 2 Married 12. Was Decedent Ever in U.S. 14. Race - American Indian, Arixed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: IIWWĬ If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) news stand operator self- employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William H. Kastner Loretta M. Aman 19a. Informant's Name/Relationship (Type, Print) Mary M. Dickerhoof 19b. Mailing Affress (Street and Number of Bural Route Number City or Town, State, Zin Code) 21502 friend 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Department of H Important: If its any injury or ot once. 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 7/19/2012 MD Cresaptown Donation 5 Other (Specify) Signat re of Funeral ervice Linensee 22. Name a Scarpell Ferieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter oncerning the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed to d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 Yes 2 🗌 No Yes 2 No ours after death. eral Director; After this certifics filled in by the funeral director, r Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 700 မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m D 19, 2012 D 6017505

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

A-JB011 TA
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of M Registrar	-	epartment of H C <i>ertificate of D</i>			liene leg. No. 2 (112	23499
H	Physicia		1. Decedent's Name (First, Middle, Last) Lenore Lam				2. Date of Dear July 19		Year	3. Time of Death 5:27 and
i V	Medic Examin		4a. Facility Name (if not institution, give street and number) 2901 Leisure World Blvd.		4b. City, Town, or Silver S			4c. County	of Death	
	Funeral		100 /0 0001	e (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
	Director		Usual Residence of Decedent	64 _{Yrs}			Aug 22,	1947		York, NY
	aryland a-f sho fied at	ector	10a. State 10b. County Florida Palm Beach	10c. City, Town or Boca R					11	0d. Inside City Limits 1x√ Yes 2 □ No
	the Man or 28, se noti	Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Coun	
	th with ms 23a must I	Funeral Director	2077 Exeter E. 11. Marital Status 12. Was Decedent I	Ever in 11 S	334		ncify Ves or No-	USA	e - America	an Indian
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 \(\bigsim \) Never Married 2 \(\bigsim \) Married 3 \(\bigsim \) Widowed 4 \(\bigsim \) Divorced 1 \(\bigsim \) Yes 2 \(\bigsim \) If Yes, Give Year or Dates.	No No	13. Was Decedent of His If Yes, specify Cubar1 ☐ Yes 2 ☐ No		Rican, etc.)		ck, White, e	
2-0	"natul edical	Completed	15. Decedent's Education (Specify only highest grade completed)	1 (G	ecedent's Usual Occupa Give kind of work done de		ing	16b. Kind of B	usiness/Inc	lustry
21215-0036	within 7 giene. er than the M		Elementary/Secondary (0-12) College (1-4 or 5	0+)	e. DO NOT use retired) ucator			Educa	tion	
Maryland	dental Hy rrked oth	To Be	17. Father's Name (First, Middle, Last) Benjamin Lam			18. Mother's Nam Frieda	e (First, Middle, N Kaplan	Aaiden Surnam	9)	
Mary	2 should the and N 27 is ma		19a. Informant's Name/Relationship (Type, Print) Lillian Glaser - Cousin	1.1	Mailing Address (Street a.		n Route Number,		State, Zip C	ode)
ore,	of Heal		20a. Method of Disposition 1 🏝 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of D	Disposition (Name of crematory or other place		Date	20c. Location		wn, State
Baltimore,	it. Page intment intant: injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Significant earlier service Licensee		Gardens Cem	7-	22-12			sant, NY Service
Ba	Depar Impol any ir		Film Dand	20	22. Name and Address		*			, VA 22310
	Medical Examiner bhysician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):		OME			10	Interval Between nset and Death
). Box 68760	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Medical I	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown d. 23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3	/			te of delive	ery Day Year
s, P.O.	es that signed	by	Part II. Other significant conditions contributing to death b	ut not resulting in t	the underlying cause give	en in Part I.	23e. Did tol			e cause of death?
Division of Vital Records,	e law requir has been a ge 2 should	Completed					24a. Was a autops perfor	n 24b.	Were autop prior to cor death?	osy findings available mpletion of cause of
<u>e</u>	ian; Th ertificate ctor, pa	Be Co	25. Was case referred to medical examiner?			ce of Death (Chec		2 No	1 Yes	2 L Y No
Ž	Physic rthis ce eral dire	유	1 Yes 2 No 1 Inpati 27. Manger of Death 28a. Date of inju	ent 2 ER/Outpa		4 L Nursing Ho	me 5 Reside			
ono	ending sath. or: After	Certificate:	1 Natural 5 □ Pending (Month, Da 2 □ Accident □ Investigation	y, Year) inju	yry work?	Yes 2 No		, in injury occur.		
Divisi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injudiding, et	ury - At home, farm c. (Specify)	ı, street, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of a only one) 3 Certifying Nurse Practitioner: To the	xamination and/or in	nvestigation, in my opinior	n, death occurred a	the time, date an	d place, and du	e to the cau	use(s) and manner stated.
	Vithir Volta	2	29b. Signature and title of certifier		29c. License	number		29d. Date signe		
	10		30. Name and address of person who completed cause of c	leath (Item 23a) (Tvi	<i>D233</i>		(juy !	7,20	72
	10		VICTOR M. PRIEGO MO	6420 RC	CKLEOGE	DR. B	STITES 0	A MI	20	181.7
	Star Registra		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year RONALD DUWAYNE LYTLE Medical TIIT.V 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PR.GOERGE'S SOUTHERN MD HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) SEP. 27, 1951 Hours Director 539-52-8613 1 **X** M 2 □ F TAJ A 60 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES LA PLATA MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 CORNWALL COURT U. S. 20646 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married <u>Ş</u> ★★Yes 2 □ No If Yes, Give Year or Dates 2 8 Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SERGEANT MAJOR S. ARMY and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment. Important: If item 27 is marked any injury or out. RICHARD T. LYTLE SIGNA G. MOEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHEA LYTLE/SPOUSE 101 CORNWALL CT., LA PLATA, MD 20646 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/25/2012 CHELTENHAM, MD VETS.CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. ke of Funeral Service Lice on M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Interval Between Onset and Death Immediate Cause (Final heroscieratic Physician! disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence on): Exami or Attending Physician: The law requires that the death certificate be executed and I-tran. physician ars the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? fo Month Year Day Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page 1 🗌 Yes 2 🗆 No Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 LINO Other: 1 Yes ျှ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury nours after death. neral Director; After thy filled in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 **To the I** Gertifying Nurse Practitioner To the best of my knowledge prouted at the time, date and plans, and due to the cause(s) and mainler as state 29b. Signature and title of certifier 1

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed çause of death (Item 23a) (Type, Print)